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Reports concerning mental retardation in Washington, D.C. include the following: an introduction and assessment of the problem; programs and resources available and being planned; recommendations of the mental retardation committee; commentary on prevention and related services; suggested roles and functions of four anticipated mental retardation centers; and problems in implementation. Appendixes list members of the mental retardation committee and of task forces and working parties. (RJ)

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Comprehensive Mental Retardation Plan

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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Final Report of Mental Retardation Committee

EC 004 026

DEPARTMENT OF PUBLIC HEALTH
Government of the District of Columbia

ACKNOWLEDGMENTS

The involvement of the community, of all agencies and institutions, in this planning process, has expanded continuously from the first planning meeting held on September 9, 1964. As of today, some 300 persons have taken an active role in the planning efforts and about another 100 have participated for the first time in recent months. The community owes them - the planners - a debt of gratitude. Their interest and willingness to serve assures the success of this planning effort. We owe special thanks to those who have chaired the various groups, for their extra time and efforts, and for their leadership. I am sure that our planning people would be the first to express appreciation for the leadership of Mrs. Dorothy Reese, the first Chairman of the Mental Retardation Committee, the parent planning body; and to Dr. Dorothy Ferebee, who has been Chairman of the Mental Retardation Committee since June of 1966.

In the final analysis, however, the community should be most pleased with efforts of those 400 persons who have so generously given of themselves and who are continuing to give of themselves in this most important task. They recognize planning as a continuing responsibility to be shared by the total community.

Murray Grant M.D. D.P.H.
Director of Public Health

APR -- 1969

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I. INTRODUCTION

On October 11, 1961, President Kennedy appointed a National Panel on Mental Retardation. The reports submitted by this Panel a year later became widely used as a guide for action on behalf of retarded persons and their families. A specific recommendation directed the Secretary, Health, Education, and Welfare to authorize grants to States for comprehensive planning in mental retardation. On October 24, 1963, P.L. 88-156 was passed by Congress. One of the major purposes of this Law was to assist States, including the District of Columbia, to "plan for and to take other steps leading to comprehensive State and community action to combat mental retardation...".

In the District of Columbia, the D. C. Department of Public Health was designated by the Commissioners as the agency to convene this activity. This Department applied for and received a $30,000 grant and a later supplementary grant with which these planning activities were to be conducted.

The charge to this Department, as stated in the application for the grant for mental retardation planning, included the following:

1. An assessment of the extent of the mental retardation problem, the nature of existing services and programs, and the resources for research and professional training in the field; and a determination of the additional services, personnel, facilities, and other resources needed. (Assessment should include existing and needed services and resources in the fields of education, employment, rehabilitation, welfare, health, and law).
2. The selection of goals towards which to develop a coordinated program for the prevention of mental retardation and the delivery of comprehensive services for the mentally retarded.
3. The development of a plan for:
    a. Establishment of administrative and other mechanisms necessary for effective coordination of activities with respect to financial participation, consultative services, training, research, application of standards of care, and services for the diagnosis, prevention, treatment, and amelioration of mental retardation.

    b. Identification of those individuals in need of services (case finding).

c. Initiation of a program of coordinated services, including diagnostic, therapeutic, home care, counselling, schooling and vocational preparation, and day and residential care available to all mentally retarded persons in the State.

d. Provision of essential planning (including continuing re-evaluation) for mentally retarded individuals of all ages.

e. Provision of an approach to technical, professional, and patient education and training for the District of Columbia.

4. Stimulation and development of greater public awareness of the mental retardation problem and the need for combating it.

5. Identification of the need and development of proposals for legislative action required to assure the above and to fully protect the rights of the mentally retarded.

6. Coordination of these mental retardation activities with related program activities in or available to the District of Columbia through local, Federal, voluntary and private funds.

Convener Role - In approaching the problem to combat mental retardation, it is necessary to recognize the scope and complexity of this task. Planning in this area is a process aimed at assuring that, "...an individual receives the services he needs, when he needs them and in the amount and priority he requires...". (Report to the President, National Action to Combat Mental Retardation, page 74, October 1962, GPO). The implication here is that a continuum of services is required. The characteristics of this continuum are described in the following manner in the Report to the President (op. cit., page 75) "Some of the services are rather closely related to one another and may be offered by the same agency, but in general one should free himself from any fixed preconception as to how the individual component services should be aggregated or grouped either physically or administratively."

The concept of continuum of services, free from a fixed administrative model, served as a point of departure in the planning process, and indeed, became the basis for the convener role adopted throughout this process. Public and private agencies have entered as equals into the development of recommendations to combat mental retardation. Because of this, the plan that evolved is concerned more with strategy and less with tactics; more with general program development needs and less with administrative control. Unquestionably, these tactical and administrative control problems must be faced, but not until the major parameters of the problem and directions for solution have been identified. To cast the role of the planning activity in terms of agency responsibility might well have blocked the types of discussion, decisions, and recommendations that developed as a result of the approach taken.

One obvious disadvantage of the selected approach is that recommendations made by the participants do not necessarily reflect policy commitment on the part of sponsoring agencies.

The Planning Process - In order to meet the requirement of broad community participation in mental retardation planning, the decision was made to utilize a committee of the Public Health Advisory Council of the D. C. Department of Public Health. This Committee, the Mental Retardation Committee (one of six standing committees of the Council) held its first organizational meeting for planning on September 9, 1964. The composition of that Mental Retardation Committee changed throughout the planning process to allow for representation of all chairmen of task forces, working parties and committees needed to carry out the complex planning efforts. Some 400 persons have been involved in the planning process. The degree of their involvement varied according to their area of assignment. The majority of these individuals have made a considerable investment in the various planning efforts. Many served on more than one working group or task force. Nearly all are busy people and have more demands on their time than they can meet in their paid positions, so that the District Government has in a sense "borrowed of their time" with the hope that these individuals and their agencies' investments will pay dividends in the future.

Individuals who served on the Mental Retardation Committee and on planning groups are identified in the appendix.

For the purpose of exploring the mental retardation problem in depth, the Mental Retardation Committee developed 24 major planning groups with some having subgroups of their own:

Away From Home Care; Day Care; Dental Care; Education; Family and Home Services; Identification and Diagnosis; Law; Medical Care;

Also, Needs of Military Personnel and Families; Nursing Services; Retarded Offender; Personnel Needs; Preparation of Psychologists; Preparation of Social Workers; Preparation of Teachers; Prevention - Biological Aspects;

Also, Prevention - Cultural and Psychogenic Aspects; Public Information; Religious Resources; Recreation and Group Activities; Residential Care; Speech and Hearing; Transportation; Vocationally Related Services.

There have been and still are some limitations in the planning process which should be recognized.

Two major services that form significant parts of the continuum have just completed studies of their programs. The D. C. Public Schools Program has recently been studied by the Columbia University Teachers College team headed by Dr. Harry Passow. The final report was released in late 1967. That report is being studied at present and recommendations made for its implementation. The District Training School participated in the nation-wide evaluation project conducted by the American Association on Mental Deficiency, and ways are being sought to provide more depth in an understanding of that major service.

II. ASSESSMENT OF THE PROBLEM

Scope and Prevalence

The prevalence or impact of mental retardation on the community must depend on a definition of that condition. Unfortunately there is no widely accepted definition. Accordingly, estimates of the extent to which the population is affected vary. One source of variability lies in the progressive visibility of the condition as individuals mature. Only very severe degrees are detected in early childhood; in that age bracket, the percentage may be as low as .5%. During the school age period, the percentage quickly rises to approximately 3%. At this point, retardation is understood as a serious handicap of the child to meet expectations according to his age level; in other words, general intellectual functioning is significantly sub-average.

It is established that during the working-age years the percentage drops, presumably because social and economic demands are less rigorous than school expectations. There is no study that provides a statistical basis for a precise evaluation of the drop in the general population recognized as mentally retarded after the school experience is over. Perhaps that difference may be of the order of .5% to 1.0%.

In understanding mental retardation, one thinks mostly of inability to solve one's problems, to adjust to society, to live independently and manage one's affairs in a broad sense. As a working definition, it would be useful to bear in mind that proposed by the American Association on Mental Deficiency. It reads as follows: "mental retardation refers to sub-average intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior."

There is abundant evidence to indicate that socioeconomic factors significantly affect the incidence of mental retardation in a given community. Thus, in a city like the District of Columbia, with large concentrations of low-income people who are disadvantaged in many ways, it is conceivable that the prevalence rate of mental retardation may be significantly higher than the percentages presented above, and that figures of 6%-8%, especially in the school-age group, may well be more descriptive of true incidence. One can assume that this finding might occur if large-scale screenings were undertaken in educational programs.

As noted in The Report of The President's Panel on Mental Retardation:

> "The majority of the mentally retarded are the children of the more disadvantaged classes of our society. This extraordinarily heavy prevalence in certain deprived population groups suggests a major causative role, in some ways not yet fully delineated, for adverse social, economic, and cultural factors. These conditions may not only mean absence of the physical necessities of life, but the lack of opportunity and of motivation. A number of experiments with the education of presumably retarded children from slum neighborhoods strongly suggest that a predominant cause of mental retardation may be the lack of learning opportunities or absence of 'intellectual vitamins' under these adverse environmental conditions. Deprivation in childhood of opportunities for learning intellectual skills, childhood emotional disorders which interfere with learning, or obscure motivational factors appear somehow to stunt young people intellectually during their developmental period. Whether the causes of retardation in a specific individual may turn out to be biomedical or environmental in character, there is highly suggestive evidence that the root causes of a great part of the problem of mental retardation are to be found in bad social and economic conditions as they affect individuals and families, and that correction of these fundamental conditions is necessary to prevent mental retardation successfully on a truly significant scale".

And from Statistical Notes, December, 1966 of the D. C. Department of Public Health:

> "In 1966, the Bureau of the Census, at the request of the Office of Economic Opportunity, delineated "poverty areas" within major metropolitan areas. Poverty areas were defined as those census tracts which fell in the lowest quartile on a composite index of five poverty-linked characteristics (in 1960) in Standard Metropolitan Statistical Areas of 250,000 population or more".

> "Of the 125 census tracts in the District of Columbia, 59 (or 47 percent) are in poverty areas. By this definition, almost half (46 percent) of the population of the District lived in poverty tracts in 1960".

In the poverty areas of the District of Columbia in the years 1962-64, the infant death rate was 40.5 per 1,000 live births; the neonatal death rate was 28.9 per 1,000 live births; the fetal death rate was 20.4 per 1,000 live births; there were 14.4 live births weighing 2,500 grams or less at birth per 100 live births; 32.7 illegitimate live births per 100 live births; and 22.6 live births with no prenatal care per 100 live births.

For the District of Columbia, there can be estimated a probable number of retarded individuals based on prevalence figures reported in the literature. These are shown in the following table and should be considered as conservative estimates because no allowance is made for the increased prevalence due to low socioeconomic conditions which are admittedly widespread throughout the District's population.

Estimated Number of Mentally Retarded Residents
District of Columbia, 1965

Age	1965 Population	Estimated MR Rate %	Estimated Cases
All ages	802,000		
0-4	84,700	.5%	437
5-19	188,700	3.0%	5,661
20-24	64,900	1.0% 1/	649
25 and over	463,700	1.0%	4,637
		Total	11,384

1/ A figure of 6% was obtained as the current rejection rate of D.C. men who scored less than 10 on the AFQB test at the time of Selective Service screening. If this prevalence was applied to the age group 20-24, admittedly a possible overestimate, the number of mentally retarded in the District of Columbia would be considerably greater.

III. PROGRAMS AND RESOURCES AVAILABLE AND BEING PLANNED FOR

The following cannot be considered a complete listing of all programs and resources now available, nor are the figures used here necessarily up-to-date. It is difficult to get current information, since agencies purposes for collecting information and statistics do not necessarily coincide with mental retardation planning needs.

Included are some of the new programs being planned, whether budgeted or not. The rationale for including projected services which have not been budgeted comes from the desire to share the new developments as an aid to continuing planning.

A. Away-From-Home Care

While the general public received services through foster homes, nursing homes and boarding homes, the availability and extent of need of these services for retarded persons is not known. It is understood that there is greater need than can now be met by present resources.

With respect to half-way house programs, the D. C. Department of Vocational Rehabilitation operates the first such program which began in the fall of 1965; twenty-two men have been served by that program thus far.

B. Day Care

Of 78 day care centers licensed by the Health Department, 24 knowingly accepted retarded children, as of 1966. Of the 3,000 children served by these centers, less than 1% were identified as retarded.

The D. C. Department of Public Health has a relatively new program, The Developmental Services Center of the Area C Community Health Center, which opened in mid-1967. This program, to which the Health Department will contribute about $110,000 this year, also calls for other agency involvement. The development of a similar program in Area B is being planned and a request for $127,000 in new funds for FY 1969 for that program has been made.

The Jewish Foundation for Retarded Children recently opened a Comprehensive Day Program for profoundly to moderately retarded adults. The program will gradually expand to serve some 30 persons, 16 years and older.

C. Education

D.C. Public Schools

- a) Trainable children - 45 classes with 460 children enrolled;
- b) Educable children - 5,000 mildly retarded children served in combination of regular classes and resource teachers.
- c) Head Start Program - during the summer of 1967 served 51 retarded children;

D.C. Children's Center

- a) 368 enrolled in education program of District Training School;
- b) 22 retarded children at Maple Glen.
- c) 41 retarded children at Cedar Knoll.

Kennedy Institute - (parochial school of Washington Archdiocese) 110 children enrolled, 46 from the District of Columbia

Private Schools - some 200 D.C. retarded children among all children served;

St. Maurice Day School - 8 D.C. children of 90 total;
Pilot School for Blind Children - 10 D.C. children of 17 total;
St. John's Child Development Center - 30 D.C. children of 92 total;
Jewish Foundation for Retarded Children - 33 D.C. children of 71 total;
Kendall School for Deaf Children - several classes of mildly retarded children among 124 D.C. children:
Montgomery County ARC Preschool Program - 2 D.C. children;
D.C. Society for Crippled Children - 31 D.C. children of 96 enrolled.
St. Gertrude's School of Arts and Crafts - 5 D.C. children of 45 total.

D. Diagnostic and Evaluation Services

Special Clinics for Retarded Children

Gales Clinic for Retarded Children - D.C. Health Department operation. The number of children who have received direct services by the Clinic has grown to over 1,100 since the Clinic's opening in 1955. 158 children who are attending Child Health Clinic are seen routinely by the Mental Retardation Team from Gales.

Georgetown University Hospital's Child Diagnostic and Development Center - served a total of 151 children from October '66 to October '67; 131 were D.C. children.

Howard University's Child Development Center - served 56 children during calendar year 1967; 47 were D.C. residents; intake was stepped up to about 2 per week in July of 1967 and they anticipate further acceleration to about 3 children/week by February, 1968.

Children's Diagnostic and Study Unit of NICHHD - located at Bethesda Naval Hospital; serves about 2 children/week (all military dependents);

Other Evaluation Services:

Children's Hospital Special Clinics - Neurology and Birth Defects;

Walter Reed Hospital - Neurology;

D.C. General Hospital - Mental Deficiency Clinic;

Children's Convalescent Hospital;

DVR Evaluation Services;

D.C. Schools - Pupil Personnel Services.

E. Nursing Services

Visiting Nurse Association
Nursing Services at District Training School and Jewish Foundation for Retarded Children
Public Health Nursing Services - D.C. Health Department Report on visits to or on behalf of retarded children FY'66. Total Visits - 1,475
Home Visits - 502 new, 576 revisits
Office Visits - 9 new, 46 revisits
Clinic Visits - 5 new, 20 revisits
School Conferences - 20 with co-workers, 13 children
Other Visits - 15 new, 12 revisits.

F. Personnel Needs

Many universities and colleges in the D.C. area offer preparation of one kind or another. The University of Maryland, Catholic University and George Washington University offer special education courses leading to at least The Masters' degree: other institutions offer special education courses.

The major thrust for preparation of a variety of personnel will come from the Georgetown University-Affiliated Facility for Mental Retardation, when this is ready for operation. There will be involvement of the other universities through the consortium.

G. Recreation and Group Activities

D.C. Recreation Department

1. Preschool programs at Lincoln and Banneker Centers are serving some 50 children this year; there are three half-day programs offered year around;

2. Emery recreation program for 30 children and youth;

3. Lincoln Center recreation program - about 20 children, youth and young adults;

*4. Cardozo Services Program - alternate Saturday mornings;

5. Social Club for Youth and Adults - one Friday night a month;

6. Shady Hill Day Camp (for orthopedically handicapped children) of 108 enrolled, about 27 retarded;

7. Sunny Grove Day Camp - 92 children for four weeks each;

New D.C. Recreation Department Program to begin in 1968**

The new program, staffed by 22 persons, will be located at or in the area of the following 5 new recreation centers for retarded persons:

1. Deanwood - 49th and Nash Streets, N.E. - 5 staff;
2. Douglas Dwellings - 2000 Alabama Avenue, S.E. - 5 staff;
3. Trinidad - Childress and Holbrook Streets, N.E. - 5 staff;
4. Banneker - Georgia Avenue and Euclid Street, N.W. - 3 staff;
5. Developmental Services Center at D.C. General Hospital - 4 staff;

Kennedy Foundation

Shriver Day Camp - served 68 D.C. children for 3 weeks, June 1967;

Winter Program: During the school year, a program is offered every Saturday at four centers and on alternate Saturdays at the Cardozo swimming pool;

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*Now Available

**There will be afternoon, evening, weekend programs; some at the Centers, but in some instances, retarded children will be worked with individually out of their own homes.

Camp Tapawingo

Resident camp for 226 retarded children and youth; twenty-three from D.C. attended in summer of 1967;

District Training School

About 700 residents attended day camp held on the grounds: there is also a year 'round recreation program:

Help for Retarded Children, Inc.

HRC operates a Friday night social club for youth and adults, and during the summer provides some Saturday programs;

Help for Exceptional Little People

Operates Friday night programs for youth and adults;

CHAP - Air Force

Resident Camp for 35 children; served 5 D.C. children summer 1967; also 6 D.C. children in Bolling AFB swim program.

H. Residential Care

The District Training School is serving some 1,250 retarded persons; St. Elizabeths Hospital cares for more than 300 retarded persons; Jewish Foundation for Retarded Children, St. Gertrude's School of Arts and Crafts and Partridge School serve D.C. children also.

I. Speech and Hearing Services

Special Services

D.C. Schools provided for some needs of trainable children, using 2 speech correctionists;

District Training School employed a speech therapist who provided services to 32 retarded persons at the Children's Center:

Kendall School - four classes were serving primarily mildly retarded children;

Other Services - through a variety of agencies, offered services to about 950 children suspected of being retarded or having brain damage.

J. Vocationally Related Services

Some 306 clients were served by the Department of Vocational Rehabilitation in FY 1966 where mental retardation was the primary disability;

Help for Retarded Children, Inc. has a pre-vocational training program, a sheltered workshop and a training program for employment serving some 200 persons each year;

The USES provides special placement services for handicapped workers, including the retarded.

K. Other Resources

1. Community Attitudes

There is fortunately a favorable climate for planning for mental retardation, with much interest in mental retardation and a willingness to invest time and effort in the planning process.

2. Unique Role of D.C.

This being the Nation's Capital, there is an expectancy about programs which is hopeful, but in view of unique problems, may not be realistic. However, with the central administration of federal agencies and many national agencies being located here, there has been the advantage of the involvement of a number of federal and national agency personnel, in the planning efforts.

District of Columbia being a city-state has also made it possible to do some in-depth assessment of needs and resources, an advantage that states have not enjoyed.

IV.

RECOMMENDATIONS OF THE MENTAL RETARDATION COMMITTEE

RE EDUCATION, IT IS RECOMMENDED

1. That there be established in the school system the position of assistant superintendent for special education;

2. That there be established in the school system the position of director of public information, whose services would be beneficial to all areas, including that of special education;

3. That there be expansion and improvement in pupil personnel services to permit more effective placement of all children;

4. That there be expansion of services of the curriculum department and improvement of exchanges among various levels in the schools and among the curriculum department and other community agencies, notably the vocational rehabilitation agency;

5. That a tuition grant of perhaps $1200 per annum be available to the retarded child who must be withdrawn from public school and enrolled in a private school, this to provide needed continuity in education and to discharge the community's responsibility for such education; to be funded as a budget item in Congressional appropriation or through inter-agency contribution (public welfare, board of education, etc.);

6. That there be established a registry of trainable children and youth in the District, this to permit effective planning;

7. That admission to a trainable class be limited to children whose primary handicap is mental retardation;

8. That placement in a trainable class be a considered, joint decision based on the child's needs (after full evaluation) and on awareness of teacher and facility assets and limitations;

9. That children who do not adjust in their first placement in a trainable class be offered other opportunities in other trainable classes;

10. That the child whose behavior threatens class progress or who does not benefit from the program be withdrawn from the class;

11. That there be preschool programs for the very young trainable child and that the upper age eligibility be extended to twenty-one; also that there be twelve-month trainable programs;

12. That a department of special education be developed at D.C. Teachers College to prepare professionals to work with severely retarded children and that there be minimal education standards for teachers of trainable children;

13. That a definitive written policy be established for the trainable programs;

14. That educators offer consultant aid to those working with the profoundly retarded and that a guide be written to assist in training such profoundly retarded persons;

RE HOME AND FAMILY SERVICES, IT IS RECOMMENDED:

15. That existing referral services be strengthened and perhaps consolidated for convenience of families, volunteer, staffs, etc. and that a directory of agencies and services be prepared;

16. That responsibioity for case-finding be emphasized in public and private agencies as is presently done in medical and educational settings, this to help detect the preschool retarded child and the retarded youth and adult likely seen first in a family service agency;

17. That birth control programs be adapted to the needs and understanding of the retarded youth and adult, with continuing supportive services;

18. That home and family agencies provide in their budgets for counseling service to the retarded, an expensive, time-consuming activity; also that the importance of continuity of care be emphasized;

19. That cooperative nursery and kindergarten classes be made available for children of the mentally retarded (and using parents as aides), this to stimulate the children themselves, instruct parents in child care, and be a follow-up as to what occurs with children of retarded parents;

20. That cooperative services be offered retarded homemakers (and fathers) by teachers, social workers, nurses, nutritionists, etc. to improve homemaking skills, this a form of home rehabilitation,

RE IDENTIFICATION AND DIAGNOSIS, IT IS RECOMMENDED:

21. That there be guidelines for the physician, this to include complete records of gestation, labor and delivery kept by the obstetrican and available to the pediatrician; an Apgar score on each delivery; all newborns given two complete examinations during their nursery stay (in addition to regular inspection), noting measurement of head circumference, height, weight and chest, transillumination of head, search for specific minor abnormalities of face and extremities associated with chromosomal defects, PKU screening; same examination given each infant at age six weeks;

22. That there be guidelines for the mother, this to include stress on six-weeks examination of infant by physician, with appointment made prior to hospital discharge;

23. That each hospital in the Washington Metropolitan Area establish a hospital committee on mental retardation;

24. That a metropolitan registry on mental retardation be established, with proper safeguards;

25. That each infant have at least one psychological screening evaluation in the first year (preferably after six months) and another in the second year;

26. That there be refresher courses for public health nurses, social workers, etc. in child development, mother-child interaction sensory function tests, screening, etc.

27. That there be guidelines for early identification in the pre-school child, this to include full and regular health supervision during first two years of life by public or private physician; annual physical and mental development appraisal during ages two to five; yearly assessment of mental development of children attending day schools, nursery schools, etc., assessment by child health clinics, hospital clinic, etc. of the mental development of their pre-school-age patients (using check list for first and subsequent visits); referral of possible retarded (preschool) children seen by all agencies, this for diagnostic evaluation and follow-up; referral to physician, public health clinic, etc. of children noted in nursery school, day care centers, etc. as not developing at normal rate, this information given to parents with suggestions for referral and further referral (if retardation is detected) to a specialized clinic in mental retardation;

28. That screening be established for the school-age child, especially those noted by teachers as having behavior or developmental problems.

RE PREPARATION OF TEACHERS, IT IS RECOMMENDED:

29. That minimum course sequences consistent with standards of the Council for Exceptional Children (NEA) be established by institutions responsible for preparation of teachers;

30. That attempts be made to have such standards adopted (for purposes of teacher certification) by the State of Maryland, Commonwealth of Virginia and District of Columbia;

31. That there be active participation by member institutions in the Georgetown University facility for the mentally retarded and other such facilities, this to provide maximum clinical field experience in graduate programs in special education;

32. That the District of Columbia seek Federal funds (through its school system) for intraining, development of curriculum guides, etc., and that the D.C. Teachers College apply for such funds for direct support of teacher preparation programs, noting that Public Law 85-926 permits separate eligibility in applying;

33. That teacher preparation programs be aware of and cooperate with planned and existing mental retardation centers and public and private agencies offering opportunity for field experience;

RE NURSING SERVICES, IT IS RECOMMENDED:

34. That there be a centralized directory of community services in mental retardation to permit optimal utilization and service;

35. That nursing records be studied to determine ability to record factual data documenting growth and development; also, that guidelines be prepared to assist in such documentation (of patient data) in a multi-faceted retardation program;

36. That nursing education curricula include theory and experience in prevention of prematurity (and mental retardation), maternal and infant care, early identification and care of children whose growth patterns deviate from the normal, methods of working with families (among them the culturally deprived) all this beyond present curricula offerings and including ancillary nursing personnel;

37. That existing nursing services be improved and provide for more constructive supervision, dynamic inservice programs, more participation in parent counseling, more support of community action to obtain needed facilities and personnel, and priority attention to nursing needs in deprived areas;

38. That nurses accept responsibility and a role in research, workshops, other professional activities and in continued evaluation of patient, family, community needs, etc.

RE PREVENTION, IT IS RECOMMENDED:

39. That prenatal services be made more useful and available (primarily in more impoverished areas) by offering mobile or neighborhood clinics, by rewarding clinic attendance (free food stamps, baby pictures, etc.), by providing transportation, etc.;

40. That well-baby and infant care services be made more useful and available through similar devices;

41. That high-risk mothers (diabetic, older mothers, known prematurity, etc.) receive special attention in public health clinics in particular, this a responsibility of the staff;

42. That toxoplasmosis testing be considered equal to 5 more important than PKU testing (though not at the expense of the latter) and be done in the prenatal clinic in the high-risk groups; also, that there be thyroid testing with abortions and prematurity, identification and follow-up of the prediabetic, and study of each case of premature separation with toxemia, again with follow-up;

43. That genetic counseling (now very limited in its availability in the District) be expanded and included testing of healthy children where there have been inheritable errors of metabolism, etc., also that there be follow-up counseling;

44. That the immediate postpartum period be used to educate the mother as to child development, family planning, need for visits to obstetrical and pediatric clinics, etc.;

45. That marital information (premarital counseling) be made a more routine service;

46. That there be Teletype networks connecting satellite clinics to a central obstetrical service;

47. That present welfare and economic improvement programs be continued and expanded, and that newer approaches be developed also, this to ease the disruption of family and resultant cultural retardation which exists in much of the impoverished urban areas;

48. That a (social) diagnostic approach be used in cultural retardation showing child-parent relationships, etc. to build on family strengths (and shore up weaknesses), on existing abilities, etc., this as used in Children's Hospital profiles;

49. That there be more daycare services available for working mothers who have preschool children, this to avoid mental (cultural) retardation which often accompanies such 'working mother' situations, with special needs for infants in their first three years of life; also, that there be concurrent training of staff (child care workers, aides, etc.);

50. That there be nursery school and prekindergarten experience for children from impoverished homes (likely age three) to offset early limitations which can later become more severe handicaps;

51. That there be for the impoverished and culturally deprived in the schools, more individual attention (through smaller classes, teacher aides, etc.) and more effort directed toward education, assuming that the child's need for security, esteem, etc. are being properly met through other home, family and community services; this all to reduce the likelihood of cultural mental retardation;

52. That programs of service include strong research arms;

53. That private hospitals be approached to determine their ability and willingness to accept more indigent patients for delivery in their obstetrical units;

54. That high-risk pregnancies be directed to special perinatal units where qualified staff, needed facilities, etc. are available at all times; likely medical school (university) hospitals; to offer inpatient care beyond 28-32 week when there is hazardous complication of pregnancy and provide metabolic monitoring of the fetus during labor (and immediate delivery of required), access to neonatal intensive care unit, monitoring of the newborn and immediate care as needed, follow-up in special clinics throughout infancy and childhood, other particular needs of these high-risk babies who have high proportion of abnormalities; note that two such special perinatal units are required for D.C.

55. That physician, nurse and nurse aide time be doubled in the child health clinics;

56. That health aides be recruited, employed and trained to seek out patients, families, etc. who are receiving child health care in the clinics, and that these aides come from and know the community which the clinics service;

57. That clinic staff treat clinic patients with greater courtesy; that clinic staffs be increased; that clinic staffs be given training in interpersonal relationships;

58. That social services, counseling, etc. be more available to families attending the child health clinics;

59. That routine screening for hearing, speech, vision, neurologic and psychologic, dental and other conditions be offered at appropriate times during preschool years; that there be urinalysis, hemoglobin, other laboratory testing (note that iron deficiency anemia is wide spread by age one in D.C. and causes decreased resistance to infection); that there be neonatal testing for G6-PD deficiency; all these through the child health clinics;

60. That there be play space for children waiting to be seen in the clinics, and group sessions for mothers while waiting, conducted by health educator, social worker, nurse, etc.

61. That there be systematic forwarding of information from the child health clinic to the school health service for inclusion in the child's school records, to Headstart, etc.;

62. That pilot programs be established for infants and children facing higher risk of becoming mentally retarded if it develops that complete programs cannot be established for all infants and children, and that this priority be followed until resources permit the larger programs;

63. That child health clinics be placed in neighborhoods having many indigent families; that these clinics keep evening hours and offer emergency services, treat acute illness, provide screening tests and follow-up, accept referrals, etc.

64. That full use be made of private medical resources which may be funded under Medicaid Title 19, this to be a cooperative effort by public and private health services;

65. That family planning, its workings and benefits, be made available to all interested, noting that too frequent pregnancies, for instance, greatly increase prematurity and possible resultant mental retardation;

66. That all indigent mothers be included in health programs and not only those at high risk, noting that low-risk mothers, by defaulting on needed care, can quickly become high risk and require care that may be too late;

67. That there be emphasis on comprehensive patient education (including health, nutrition, family life, etc.) and that this be offered in neighborhoods, housing developments, etc.;

68. That health, welfare, social agencies, etc. use groups and group techniques in working with the retarded, this to enhance interpersonal relationships, etc.;

69. That more attention be directed to emotional problems of the retarded, their families, etc. through expanded diagnostic and treatment services;

70. That public rehabilitation facilities be more available for evaluation of retarded adults, this to determine need for aid or ability to function independently;

71. That social agencies develop volunteers and non-professional staff to extend supportive assistance they now give to the mentally retarded;

72. That follow-up services and referrals be improved when a new kind of aid is required or if family moves elsewhere;

73. That a guardianship program for the retarded be established, this to offer continuing supportive services, legal aid, budget and living arrangements, public assistance payee systems, etc.;

RE DAY CARE PROGRAMS, IT IS RECOMMENDED:

74. That existing programs be expanded and new ones established for the school-age retarded child not in school;

75. That centers be established for all children of preschool age, this to identify and serve the retarded child of this age and that those who cannot function in a group with normal children be grouped according to level and needs;

76. That activity centers be established for the age sixteen and older retarded youth, this with some emphasis on social development and growth and related to vocational training;

77. That all day care programs be carefully coordinated;

RE MENTAL HEALTH, IT IS RECOMMENDED:

78. That there be joint consideration and action as to emotional needs, etc. of the disturbed retarded child; this by mental health and retardation programmers and planners;

RE RELIGIOUS NEEDS, IT IS RECOMMENDED:

79. That each faith be encouraged to explicate its own position on fundamental religious questions related to mental retardation, perhaps defining the place of the retarded in the religious community, a responsibility to recognize special religious needs, etc.

80. That each faith undertake to meet these needs, once defined, through identification of retarded persons in the congregations, through designating responsible persons (at appropriate ecclesiastical levels) to develop programs of religious training (including teacher training), and through active cooperation with other faiths;

81. That a center be established with educational materials, literature, etc. on religious needs in mental retardation;

82. That training programs of seminaries include subject matter on mental retardation, religious needs, etc.;

83. That there be workshops and other opportunities for clergy to develop awareness, skills and insights into mental retardation, this through encounter with retardation problems;

84. That each faith support research into methods by which religious values and concepts are imparted to the retarded;

RE THE RETARDED OFFENDER, IT IS RECOMMENDED:

85. That studies be made of training programs needed to rehabilitate the retarded offender;

86. That studies be made of ways to utilize the individual's cumulative record, from birth to present, to provide appropriate service at given stages in life (a continuum), this record perhaps computerized as to clinic visits, etc. and thus more available and useful;

87. That research be done into the retarded offender's view of himself (wisdom of the client), his needs, value of services offered, etc.; this to aide staff also in understanding and habilitating the offender;

88. That methods be explored to offer supportive services as needed, from point of adjudication through aftercare, with emphasis on 'support' and not on 'control'; this to include total society support to the family unit;

89. That there be continuing study, diagnosis, prognosis and treatment for each individual, using observations of all who work with the person and access to flexible programs which can accommodate growth of ability and skills;

90. That there be a facility in the District for older offenders (notably sex, severely assaultive, etc.) with a flexible interior (treatment programs, progressive degrees of freedom, etc.) and a secure exterior to protect the community;

91. That there be in the four proposed neighborhood centers a separate physical area for multi-discipline study of the retarded offender, this to provide aid to the offender as well as research opportunity to the staff; placement would be by court referral, for defined reasons, for at least sixty additional days if early findings justify extension; facility should be university-affiliated, well programmed, flexible.

RE RESIDENTIAL CARE, IT IS RECOMMENDED:

92. That there be full support of efforts to pass the Model Act for Public Residential Care for the District of Columbia and that its standards enlighten and guide the administration of private programs in D.C.

93. That criteria be developed to determine the adequacy of private facilities and that compliance with these be required for institutions within or without the District which render service to D.C. children, otherwise purchase of such services implies endorsement of inadequacies;

94. That comparative studies on quality and cost of private and public residential care be kept current so that appropriate rates may be maintained;

95. That public and private administrators share long-range plans so that expansion may be coordinated with existing and proposed programs and be adaptive to community needs;

96. That public funds be available for the residential care of retarded persons who must live away from home but who cannot be absorbed into the District Training School and whose parents cannot meet the full cost of private care;

*97. That public and private residential institutions engage in a continuing self-evaluation as to their meeting or not meeting community needs and that these findings lead to positive adjustments; this consistent with the standards for state residential institutions of the American Association on Mental Deficiency; also, the AAMD evaluation project at District Training School should be continued as planned;

98. That there be systematic analysis of waiting lists and of residential populations in public and private facilities; to permit return of residents to their communities, delayed or avoided placement when possible, other desired benefits based on factual knowledge;

99. That an agency of the D.C. Government be responsible for organizing periodic conferences for discussion of new methods, techniques, etc. in residential administration to meet emerging community needs;

RE PUBLIC INFORMATION, IT IS RECOMMENDED:

100. That an extensive public information and education program be developed and implemented, using press, radio, television and other media; also, that there be published a periodical on developments in mental retardation directed to organizations and individuals interested; that a speakers bureau be formed to address civic groups, etc.; that there be a public information brochure on the D.C. retardation plan; and that the public information goals of Service Council be supported;

RE SOCIAL WORK, IT IS RECOMMENDED:

101. That schools of social work take the initiative in working with institutions for the retarded to raise the level of the social service program so that it may be used to develop student training units;

102. That large institutions be utilized to the extent possible as training centers for social work education and related disciplines;

103. That schools of social work which offer electives include a course in work with the retarded and their families, perhaps through the consortium of universities in Washington;

104. That schools of social work make conscious effort to integrate content on mental retardation into classroom courses to permit students to relate theory to practice;

105. That short-term training institutes be considered for faculty of schools of social work, with representation of all basic sequences in the curriculum;

106. That, as feasible, small volunteer agencies with little or no social service components be used for purposes of social work education;

107. That the committee on preparation of social workers meet with volunteer and public agency representatives to consider the potential for inservice training and staff development in programs in mental retardation;

108. That the committee sponsor a training institute in mental retardation for administrative, supervisory and training personnel in voluntary and public agencies;

109. That there be a central coordinating office to provide information on summer job opportunities in work with the mentally retarded;

*110. That there be a study in depth of problems in recruiting and maintaining staff at the D.C. Training School;

RE RECREATION, IT IS RECOMMENDED:

111. That the D.C. Recreation Department be responsible for coordinating joint training programs for recreation and camp personnel (paid and volunteer) for all agencies, public and private, who wish to participate;

112. That the D.C. School System and the D.C. Recreation Department jointly focus on the recreation and physical education needs of the educable retarded child, seeking new or improved methods for working with children with learning problems who are in special academic classes, one objective being to assess their involvement in recreation and group activities and to consider their needs;

**113. That support be given plans of the recreation department to develop the Lincoln Center, noting the response to year-round recreation programs by the Department and a need to provide larger facilities and more staff;

114. That workshops, institutes, etc. be available on a regular basis to agencies and persons interested, this to give opportunity for more and better training;

115. That more be done to organize youth-serving groups for the retarded, including Boy Scouts, Girl Scouts, Campfire Girls;

116. That there be expansion of recreation and camping programs for the multiple-handicapped child, noting success at including such children in present programs and an expected increase in the number of severely handicapped children;

117. That there be a coordinating structure to recruit, train and place volunteers, noting the value of volunteers in working with the retarded and the particular value of youth in recreation and group activities;

118. That effort be made to assure consideration of D.C. needs in obtaining Federal funds under recent legislation;

119. That universities, colleges, etc. with recreation, special education and physical education departments consider offering joint training programs related to mental retardation; offering joint inservice education projects; and sponsor joint projects of research in these areas;

RE TRANSPORTATION, IT IS RECOMMENDED:

120. That there be established a study group on the transportation needs of the retarded and multiply handicapped, focussing on agency coordination and sharing, etc. and seeking information on available services and present and projected needs, this leading to design of a model program;

RE VOCATIONAL AND RELATED SERVICES, IT IS RECOMMENDED:

121. That there be collaboration among professionals in vocational evaluation, as has been done in some states, this to improve programs of vocational assessment; note that the National Rehabilitation Association now has such membership;

122. That a 'job family' approach be used in evaluation to permit the client to demonstrate his full vocational potential noting that too often employment is ruled out because client's range of capability was not fully explored;

123. That a 'job family' approach be used in training the retarded to permit them more vocational adaptation and to permit more flexible placement by the responsible persons;

124. That a 'hierarchy of skills' approach also be used in evaluation, with progression from basic to more difficult tasks within the evaluation period;

125. That a 'hierarchy of skills' approach be used too in training the retarded, with planned progression from more simple to difficult in the vocational skills being taught;

126. That training be based on fairly detailed job analysis, with jobs broken down into basic parts and a sequence of instruction then determined, realizing that this is too little done at present and that many retarded may be undertrained;

127. That curricula be developed for all training programs for the retarded and that more attention be given learning theory in present vocational programs to ensure that procedures are consistent with learning capacities of the retarded;

128. That workshop programs be less competitive in subcontract bidding; that there be closer collaboration among workshops to improve work opportunity for the disabled; and that workshops explore in the local business community possibilities for prime manufacturing and subcontract work; also, that shops develop ties with selected U.S. Department of Labor programs and the University of Maryland Regional Research Institute;

129. That specialized shops consider becoming multi-disability workshops and that the proposed 'labor pool' idea be carefully weighed;

130. That workshops examine and perhaps redefine their role and functions in terms of recent challenges in rehabilitation;

131. That professionals in mental retardation concerned with providing services be given thorough orientation to the sheltered workshops in D.C.;

132. That persons making referrals to workshops be provided a system for reporting their views as to the adequacy of services offered their clients, etc.;

133. That on-the-job evaluation (preferably in the community) be used to measure capacity of the mentally retarded to perform work; that there be communication between the employer who often makes such evaluation and the vocational specialist who will do the follow-up; and that standard evaluation and report forms be developed to aid in training and placement;

134. That there be a directory of programs which provide training services for the retarded, with notation as to the level of retardation for which the program is designed;

135. That there be in each high school a unit similar to the Eastern High School project, with a base staff working in the junior high schools which feed into the high school;

136. That there be a uniform testing program in vocational planning on the junior and senior high school levels, perhaps developed by the U.S. Employment Service or the Department of Vocational Rehabilitation;

137. That there be study of standard sampling procedures for identification of ability levels at agencies which deal with unemployed adults (public welfare, employment service, social security administration, vocational rehabilitation, etc.).

RE HEARING AND SPEECH SERVICES, IT IS RECOMMENDED:

138. That hearing tests be compulsory for all children before they enter school, whether public, private or parochial;

139. That audiometric screening and appropriate follow-up be a part of psychological and medical examination in the diagnosis of mental retardation;

140. That diagnostic teams in MR centers include a speech pathologist-audiologist;

141. That universities cooperate to offer to graduate students courses at all institutions, perhaps through the consortium of universities presently operating in D.C.;

142. That there be a communication system profile on those children who have handicapping or potentially handicapping conditions, recognizing that present knowledge permits such longitudinal studies (actually from birth) in audiology, speech pathology, verbal expressive and receptive speech, this to aid the child and family, to aid other specialists in making diagnosis, etc,; this to begin with auditory screening in newborn nurseries and requiring a city-wide protocol involving the schools, health centers, Head Start and day care centers, etc. for continuity and follow-up of service;

143. That there be postgraduate and inservice training courses for speech pathologists and audiologists for work in MR;

144. That habilitation and rehabilitation facilities (for the retarded) include provision for appropriate audiologic evaluation of their patients;

145. That existing and future facilities for the retarded develop additional speech pathology and audiology services, with emphasis on language and communication habilitation programming, and that such services include direct services by speech pathologists and audiologists and indirect services in the framework of other programs;

146. That universities and colleges offering separate programs in speech pathology and audiology and in special education consider offering joint training in the field of mental retardation, with student clinicians encouraged and permitted to take courses in MR, with student clinicians not given therapy assignments in MR without prior proper training with special education students (in MR) encouraged and permitted to take basic courses in speech pathology and audiology, and with departments (in these academic areas) cooperating by having at least one member on a graduate student or thesis committee (in MR) from the other department;

147. That departments of speech pathology and audiology and of special education sponsor joint clinical, research and education projects; this to include orientation programs for nurses, parents, teachers, etc., and workshops and conferences, etc., on diagnosis, speech improvement and linguistic skills, and collaborative research;

148. That departments of special education employ a specialist in speech pathology and audiology for consultation in developing a speech and language improvement program, and that departments of speech pathology and audiology encourage staff to improve their awareness of MR before committing themselves to programs in that area;

149. That these departments develop an appropriate referral system, share caseloads, and exchange teaching aides in MR:

RE DENTAL CARE, IT IS RECOMMENDED:

150. That there be a pedodontist with training in MR for the dental facility at the proposed new school for trainable children in the Lamont-Riggs area; duties to include care of children housed there (200 of the 424 trainable now enrolled in D.C. Public Schools) and dental service at D.C. General Hospital for those retarded not treatable at the new school; pending completion of the school, this pedodontist would offer care and services (for the retarded) in morning sessions at D.C. General Hospital and in afternoon sessions at the Sharpe Health Schools; this pedodontist should be at least GS-14, step 5, and should have adequate staff support;

151. That dental services in the new core building at D.C. General Hospital be available to retarded persons who cannot be treated successfully at more general clinics;

152. That there be continuing postgraduate courses for community dentists in treatment of the handicapped and retarded;

153. That the Department of Public Health develop a pamphlet on home dental care for families of retarded children;

154. That dental services for the retarded be related to similar medical services, not a subordinate or subspecialty service with inadequate funding;

155. That the D.C. Dental Society prepare a registry of dentists who will provide dental care to retarded persons on a fee basis; that the society collaborate with the D.C. Department of Public Health to develop an education program directed to parents of retarded children; and that the society itself become a source of information (speakers, films, etc.,) on dental care for the retarded;

156. That reference to mental retardation be included in the National Children's Dental Health Week;

157. That the Working Party on dental care collaborate with the new MR Committee of the D.C. Dental Society;

RE AWAY-FROM-HOME CARE, IT IS RECOMMENDED:

158. That small boarding homes be provided for retarded adults who may be economically self-supporting but require such services as medical care, assistance with employment, leisure time supervision and other social protective aid;

159. That there be eight half-way houses receiving persons directly from the D.C. Training School, and that there be one each for males and one each for females in the four designated community health center areas, and that there be opportunities for mixed activities;

160. That there be a program of foster-home care for retarded children, community oriented and located in or near the community health centers, with program staff to recruit foster homes, provide continuing support to the children and foster parents, etc., noting that such homes might be best located near special schools, clinics, etc.;

161. That there be development and expansion of short-term residential placement of retarded children with social, behavioral, familial or physical problems, this to offer intensive care, evaluation and treatment and lead to the quick return of the child to his family;

162. That there be recognition of the need for evaluation and medical treatment of retarded persons in foster homes, half-way houses, residential facilities, etc., who are not under the care and supervision of their parents;

163. That information of school services be available to physicians (who are likely to make the first diagnosis of mental retardation) and that physicians forward to specified persons in the school system the fact of a MR diagnosis, etc. on the child prior to entry into school, this to aid in proper placement in special education classes, etc.;

164. That practicing physicians in the greater Washington area have available a directory of facilities for diagnosis, care, etc. of handicapping conditions;

165. That there be continuing cooperation by the D.C. Department of Public Health and the D.C. Medical Society in the review of medical programs and the implementation of specific recommendations, with the journal of the Medical Society a means for making known such approved recommendations;

166. That physicians be aware of likely family attitudes etc. in accepting the fact of retardation in the new-born period and that authoritative genetic counseling be considered for the parents regarding future pregnancies;

167. That the four major pediatric centers in D.C. (Howard University Hospital, Children's Hospital, D.C. General and Georgetown University Hospital) designate a neonatologist and form a specialty team for consultation during the new-born period, this service made known to all physicians who might be involved with infants in the neonatal period;

168. That retarded children receive the same preventive pediatric care given other children, with the physician making certain that all contributing defects are noted through referral to a specialty clinic or other exact arrangements;

RE THE MILITARY AND THEIR FAMILIES, IT IS RECOMMENDED:

169. That civilian agencies providing service to dependents of military personnel be aware of the civilian health and medical program of the uniformed services, whose fiscal office in D.C. will make direct reimbursement;

170. That the U.S. Navy and the Marine Corps establish a program for handicapped children in metropolitan Washington;

171. That there be a survey of child, parent and family needs, present facilities, etc. of the various military components in the Washington area, this to lead to recommendations for new or expanded services;

RE CHILDREN'S AND FREEDMEN'S HOSPITALS, IT IS RECOMMENDED:

172. That there be financial reimbursement for inpatient and outpatient services which more adequately reflects costs to these hospitals, this for patients for whom the Department of Public Health has assumed payment responsibility, noting that inadequate reimbursement results in chronic operating deficits at these two hospitals;

173. That there be a comprehensive survey of the department of pediatrics to determine methods of operation, available facilities, etc., and that this lead to long-range planning and expansion in quantity and scope of services which more realistically provide for the needs of the population which the department is required to serve;

174. That the department of pediatrics have a defined future role which might be as a wide-ranging treatment facility for all types of illnesses or as a specialized referral center for correction of certain

defects, care of the seriously ill, etc., this better defined role to result from planning and decisions at policy levels;

175. That there be a closer working relationship between the department of pediatrics and the crippled children's unit, the latter a service experienced in handicapping conditions, and that there be some consolidation of services;

176. That there be a closer working relationship between the department of pediatrics and the department of psychiatry; noting that separation of psychiatric service from D.C. General Hospital has made it difficult to obtain psychiatric aid for the emotionally disturbed child;

RE SCHOOL HEALTH SERVICES, IT IS RECOMMENDED:

177. That the school health program especially in the elementary schools, be reorganized and expanded to provide an extension of those services available in the child health clinics, this to include a first-aid or health room in each school, a full-time nurse or health aide in each school, a full-time social service case worker at least in certain schools in low-income areas; more frequent access to pediatric consultation for each school when medical, behavior or learning problems are first noted; expanded health (and sex) education in the curriculum for all grades, with concurrent training for teachers; health education for parent groups; instruction in accident prevention; routine periodic health appraisal and screening, with improved follow-up for habilitation and training; and a foolproof system to ensure completed referral to health centers and hospitals, with a prompt return (to the schools) of findings and information.

*--AAMD evaluation project has been completed.

**--The Lincoln Center program has been instituted.

V. COMMENTARY ON PREVENTION AND RELATED SERVICE NEEDS

It has been suggested that an overwhelming majority of the mentally retarded are symptomatic products of an environment of deprivation and disadvantage. The thinking of the Working Party on Cultural and Psychogenic Aspects of Prevention further emphasizes the need for special attention in this area. The Planning Group concludes that, "Massive programs which are focused on large numbers of children as individuals must be enacted if mental retardation of cultural and psychogenic origins is to be prevented. Society might then be able to offer something of truly lasting value to these children of the poor for whom happiness is only a momentary suspension of despair". The Working Party report states, "it would seem that there is a cycle in which one generation tends to perpetuate its culturally and psychogenically determined mental retardation in the next generations. This Working Party proposes the need for massive programs over several generations in order to interrupt this cycle. The U.S. Government and private sources of support must be made to recognize the urgency in expending funds and effort approximating, and preferably surpassing, our present space exploration and war efforts. The Working Party has recognized its responsibility however, to provide the framework for the initial steps in a progression to the ultimate ideal approaches and solutions".

Certain recommendations made by this planning group can hardly be restated or summarized without doing injustice to them. However, assuming this risk, the following are salient features of each recommendation, which are set forth here to sharpen the attack needed.

Current welfare and economic improvement programs must be expanded and innovative approaches used to break the mental retardation cycles. Society must stand as a supporting extended family, as needed, and provide financial and social assistance, using all means for keeping families together, when this is appropriate.

The predominate orientation to passivity in the character makeup of the "culture of poverty", requires expanded and innovative approaches in Health Department programs so that services are more accessible and are more likely to be used effectively. Good care of mothers is a key factor.

A diagnostic approach to babies must be provided that will establish a descriptive profile of their strengths, sensitivities, activity level and reactivity patterns, as well as a diagnostic approach to the families that can evaluate child-parent, parental, child-child, and evironmental compatibilities and incompatibilities.

COMMENTARY ON PREVENTION AND RELATED SERVICE NEEDS (Continued)

Following the diagnosis, a prophylactic-therapeutic program could be developed for each child in collaboration with the parents, to augment that which the lower socioeconomic group parents can provide their infant and child.

Day care services for preschool children, including the first three years of life must be greatly expanded. Good programs prescribed individually for the children resulting from the diagnostic approach described in recommendation 48, and parent training for improved care of their own children, as well as training for child care workers and child rearing counselors, are necessary.

Establishment of specialized child and parent centers for treatment of the more complex problems (physical, emotional and/or intellectual) at earliest possible time of life.

Nursery schools and pre-kindergarten experiences for 3-5 year old children from the culture of poverty to help compensate for some of the limitations are a critical necessity.

Public schools must be better prepared to meet educational needs and the educational tasks of the teachers require support of cooperating psychological and social services. Adult education services need expansion.

It is strongly recommended that concurrent research studies be considered an essential element of every program design.

Early detection is important to allow for the earliest planning and treatment possible. A primary target for service should be the very young retarded (or potentially retarded) child and his family. Diagnostic approaches to the child and his family as suggested by the planning group on the cultural and psychogenic aspects of mental retardation should result in a prophylactic-therapeutic program for each child in collaboration with the parents. Preschool programs and day-care services become a critical necessity for these children.

Services should be family centered - not just parent centered, so as to include other members of the family - siblings, grandparents, aunts and uncles where appropriate. There is a need to conserve the family resources and strengths, since it is the family which will have the major long-range responsibility for the child.

For every retarded child, youth, and adult, there should be fostered the development of his maximum capacity, removing blocks which may prevent his reaching his potential and bringing each person as close to the mainstream of independence and normality as possible.

For those who need residential care, there must be the most advanced care and treatment possible, maximizing whatever potentials even the most profoundly retarded person may have, both for his own sake as well as for the good of the residential community.

For the families of the mentally retarded, there must be available and accessible coordinated supportive services including short and long term counseling.

There must be developed coordinating mechanisms for the provision of integrated services, their evaluation and further planning for unmet needs. Planning must be a continuous process, reflecting the changing pattern of services, new knowledge and needs of retarded persons and their families.

Basic to providing quality service to retarded persons and their families is the provision of quality service to all persons in the community.

The great bulk of service to retarded children, youth and adults and their families is provided through the general agency services providing for the health, education, welfare, recreation, rehabilitation and social needs of all persons. For the most part, the retarded person is not identified as such, except for the schools, and rehabilitation agencies which have evaluative facilities. Therefore, the goal of providing quality services to all require the attainment of two objectives which would strengthen the services to retarded persons and their families.

The first objective would be the provision of basic training in mental retardation for every personal service worker, which would provide the basis for more effective service.

The second objective relates to a six point program for developing model community services for the mentally retarded. This is the provision of a mental retardation specialist, on a full-time or part-time basis, in every generic agency. For larger agencies, there might well be such specialist for each separate department or division, again full-time or part-time.

COMMENTARY ON PREVENTION AND RELATED SERVICE NEEDS (Continued)

The private as well as the public agencies should be included under both these objectives. The tendency for personnel to work with clients who are easiest to serve quite often means less-than-average service to retarded persons and their families, and suggests the urgency of working toward these objectives.

Coordination of public and private agency effort, not consolidation, is the most feasible approach to the provision of comprehensive services.

The following material is reflective of the diversity of services required by the mentally retarded. Retardation cuts across all boundaries and any attempt to consolidate recommendations into holistic units must of necessity encounter some element of failure. Nevertheless, there is some value to be derived from a chronological approach to the problem. The following is therefore an attempt to outline the service needs of the retarded according to the various chronological life stages. Many needs of the retarded are generic and cut across all ages and some attempt to focus on this aspect is made at the conclusion of the chapter.

The chronological Life stages have been divided as follows:

Pre-Natal Life Stage

Paranatal Life Stage

Neonatal Life Stage

Infant Life Stage

Preschool Life Stage

School Age Life Stage

Post-School Life Stage

Supportive Services

&

All Life Stages

PRE-CONCEPTION LIFE STAGE

1. Health Instruction for Every Child and Youth

   Comment: Every child and youth must have throughout his educational experience, a good, sequentially arranged program of health instruction - a responsibility of education from the schools and the health department.

2. Adequate Nutrition for Children and Youth

   Comment: There must be adequate economic resources so that children and youth will have nourishing food for healthy, normal babies.

3. Family Life Education for Youth and Young Adults

   Comment: The high rate of illegitimacy is one indicator of the need for family life education beginning in the teens.

4. Family Planning Program for Youth and Adults

   Comment: Family planning should be accessible and provided for all those seeking such services, and should relate to the interconceptional period as well.

5. Genetic Counselling and Chromosome Studies

   Comment: Should be available to all carriers of genes which may result in an abnormal birth.

6. Reduction of Unnecessary and Incidental X-Ray Exposure of Young Girls and Pregnant Women

   Comment: There is need for a cumulative record of every child's exposure to x-rays, and a program for assuring that x-ray equipment meets standards.

PRE-NATAL LIFE STAGE

7. Adequate Prenatal Care (detailed past history and family history, adequate nutrition, and adequate facilities and personnel)

   Comment: Creative methods need to be pursued and motivation devices used, as appropriate.

8. Identification and Careful Monitoring of High Risk Mothers

Comment: The unwed mother, especially the adolescent, needs special services, and is part of the 'high risk' group.

9. Expectant Parent Classes

Comment: The organization and conduct of expectant parent classes, are necessary for helping parents in their understanding of human physiology, reproduction, nutritional needs, necessity for good pre-natal care, etc.

10. Avoidance of Drugs That will Produce Teratogenic Effects

11. Health Education Directed to Personal Motivation (in the acceptance and use of services)

12. Development of Specific Services Which Will Prevent or Co-rect Conditions Leading to Mental Retardation (Cooke, R.E. & Odell, G.B., Perinatal Factors in the Prevention of Handicaps, Pediatric Clinics of North America, Philadelphia, Saunders, August, 1957, pp. 595-609)

    a. Diagnosis and therapy of maternal syphilis;
    b. Adequately sterilized equipment to avoid serum hepatitis;
    c. Isolation from animal carriers of toxoplasmosis;
    d. Avoidance of diagnostic x-rays in first trimester;
    e. X-ray pelvimetry for primipara in last trimester;
    f. X-ray to determine fetal distal femoral epiphysis before elective cesarean section or induction of labor;
    g. Avoidance of specific food excesses;
    h. Adequate but not excessive intake of vitamins, minerals,
    i. Strict regulation of maternal diabetes; no ketosis;
    j. Serial BEI with family history of cretinism or maternal thyroid dysfunction;
    k. Adequate replacement therapy;
    l. Complete blood typing;
    m. Serial anti-RH titers if mother is RH negative, father RH positive;
    n. Avoidance of premature induction unless history of repeated term still-births;
    o. Adequate therapy for toxemia;
    p. Postponement of premature labor;
    q. Avoidance of breech presentation;
    r. Interruption of post-maturity.

PARANATAL LIFE STAGE (from onset of labor to delivery)

13. Provision for early recognition and treatment of obstetric complications which might impair fetal environment, such as toxemia, bleeding and infection;

14. Hospital standards and procedures which provide adequate maternity and neonatal hospital services;

15. Use of electronic monitoring devices for closer supervision during labor and delivery;

16. Tele-type system from satellite clinics to central obstetric service;

17. Services Relating to Anesthesia and Obstetrics as follows:

    a. Anesthesia

        1) Avoidance of excessive narcosis, anolgesia, systematic anesthesia;

        2) Avoidance of maternal hypertension;

        3) Routine oxygen therapy to mother;

    b. Obstetrics

        1) Careful observation of fetal heart rate;

        2) Optimal conduct of premature labor;

        3) Maintenance of fetal head below body until well-suctioned;

        4) Avoidance of unnecessary cesarean section;

        5) Extraction of head first in cesarean section;

        6) Avoidance of precipitate delivery;

        7) Avoidance of excessive oxytocin induction.

18. Careful and Complete Records of Gestation, Labor, and Delivery Should be Kept by Responsible Physician

NEONATAL LIFE STAGE (live birth to 1 month) applies to all services

19. Procedures to Prevent Chronic Neurologic Handicaps

   a. Resuscitation

      1) Apgar scoring system as routine

      2) Endo-tracheal controlled positive pressure if score is low;

      3) Adequate nasopharyngeal suction;

      4) Gastric suction in cesarean section, maternal diabetes, post-maturity.

   b. Laboratory

      1) Serum bilirubin test for fetal-maternal blood group incompatibility, all premature infants, congenital hemolytic anemias, all early jaundice (first 48 hours);

      2) Hemoglobin or microhematocrit in placenta previa;

      3) Blood culture with change in course, fever, jaundice;
      4) BEI with positive family history of cretinism;
      5) Serial blood or urine examination for phenylketonuria (and other inborn errors of metabolism);

      6) Serial urine tests for reducing substances (Benedicts' test) if family history positive for galactosemia.

   c. Transfusion

      1) Transfusion for fetal hemorrhage;

      2) Exchange transfusion in early fetal-maternal blood group incompatibility or hemolytic anemia;

      3) Exchange transfusion - large and slow - to prevent hyper - indirect - bilirubinemia regardless of cause.

   d. Poisoning

      Oxygen;
      Vitamin K;
      Parenteral sulfisoxazole.

e. Isolation

Avoidance of contact with Coxsackie, Herpes;
Staphylococcus aureus.

f. Feeding

Adequate water in relation to solute;
Lactose - free diet in galactosemia;
Low phenylalanine diet in PKU.

g. General

Careful observation of respiratory rate;
Careful nursing observation for jaundice;
Prevention of bleeding diathesis;
Careful orthopedic evaluation.

20. Babies of "high risk" mothers or the product of high risk labor and deliveries should be seen by a pediatrician at birth

21. All Newborns Should Have Two Complete Examinations During The Time of Their Nursery Stay in Addition to Regular Inspection

Comment: Routine examination of the newborn should always include: (1) measurements of head circumference, height, weight, and chest; (2) transillumination of the head; (3) thorough search for specific minor abnormalities of the face and extremities associated with chromosomal abnormalities; (4) Initial screening test for PKU.

22. Family Planning and Counselling Regarding Child Rearing and Child Development and Plans for Follow-up Obstetrical and Pediatric Visits

23. Continuity of Care From Hospital to Home

INFANT LIFE STAGE (1 month to 1 year)

24. Continuing, Intensive Follow-up Care of High Risk Infants

25. Diagnostic Approach to Babies That Will Provide A Descriptive Profile of Strengths, Sensitivities, Activity Level, and Reactivity Patterns, as well as A Diagnostic Approach to Families that can Evaluate: Child-Parent, Parental, Child-Child, and Environmental Compatibilities and Incompatibilities

26. A Prophylactic - Therapeutic Program For Each Child in Collaboration With Parents as Follow-up of Diagnostic Process

27. Appropriate Care Programs Such as Foster Day Care and Foster Home Care for Child Under One Year, to Provide Sufficient and Appropriate Stimulation, When it Can't Be Supplied in Child's Own Home

28. Adequate Protective Services for Children - Especially Appropriate as Relates to "Battered Child"

PRESCHOOL LIFE STAGE (one year to entry into school)

29. Continuing Follow-up of High Risk Infants

30. Adequate Child Health Services Meeting APHA Standards

31. Hearing Conservation Program

32. Vision Screening Program

33. Speech Screening Program

34. Programs to Improve Maternal Capacity for Child Rearing

35. Health Education for Parents Emphasizing Prevention of Illness, Proper Care During Illness, and Provision of Adequate Nutrition

36. Adequate Protective Services for Child, Before He Becomes The "Battered Child"

37. Education of Those Responsible For Care of Children, About the Biological "insults" Which May Result in Mental Retardation, such as Head Injuries, Poisoning, Infections Involving the Central Nervous System and Febrile Illnesses

38. Careful Evaluation of Child Caring Institution Programs, Providing Supportive Services to Minimize Separation Problems and Maximize Learning Opportunities and the Quality and Amount of Sensory and Social Stimulation

For the needs that follow, note this code to designate which retarded persons are in need of the service.

Degree of Mental Retardation

P - Profoundly retarded

S - Severely retarded

Mo - Moderately retarded

Mi - Mildly retarded

39. Day Care for:

    a. Children of working mothers from the culture of poverty;

    b. Children unable to function in a normal group situation - including foster day care

    Comment: P,S - Quality day care program for children of working mothers, including infants and children under 3 years of age, should be greatly expanded, to help with the prevention of culturally and psychogenically determined mental retardation. It is further suggested that each mental retardation center provide day care services for those children unable to function in a normal group situation.

40. Child Sitting

    Comment: P,S Mo, Mi - Child sitting can be easily taken for granted, but provides a valuable service, in allowing the parents some relief and helps them maintain their social contacts, an area of vulnerability for parents with retarded children.

41. Homemaker Service

    Comment: P,S Mo, Mi - This service is necessary for those emergency situations where the caretaker is out of the home and child is to remain in his own home.

42. Foster Home Care

    Comment: P,S Mo, Mi - One recommendation suggests a program of foster home care for retarded children, located if possible, adjacent to or near community health centers.

It is apparent that it will not be possible to expand present foster home services without adding other elements to the program, as follows:

a. Increased foster home payments over present rates for usual care, and on a scale which would reflect the care required, the continual training needs of foster parents, etc.,

b. Built-in assistance to foster parents, suggesting more staff and foster parent involvement in the care and development of the child;

c. Continual training activities of foster parents, raising their levels of competency in dealing with retarded children;

d. Through the previous 3 suggestions and other motivating devices, raising the status of this kind of service, so it becomes an attractive area of service, helping with recruitment and maintenance of parents for the program;

A program such as this should be considered by public and private agencies which presently offer foster home services. For many children, where the alternative is residential care in a private or public institution, costing around $10.00 per day, the savings through a foster home care program could be considerable. A theoretical program providing care for 50 retarded children at an average of $5.00 per day would save about $90.000 per year. The economics while appealing for a number of reasons, do not take into account the possible greater benefits to the child cared for in a fosrer home as opposed to a residential facility or even his own home in some instances.

43. Small Group Homes

Comment: P,S Mo, Mi - Small group homes are necessary where there is insufficient good foster home care.

44. Short Stay Homes

Comment: P,S Mo, Mi - Short stay homes or facilities are necessary for some children whose parents are unable to care for the child because of an emergency in the family or need for relief from care of the child for a time.

45. **Home Training Program**

Comment: P,S Mo, - Home training programs relates to a service to the child and family in the child's home, assisting with child's training and fostering the parent role in the training process.

46. Home Aide Programs

Comment: P,S Mo, Mi - This service provides physical care of the child, but other kinds of supportive assistance may be offered - an especially needed service for the profoundly retarded child.

47. Short Term Residential Treatment Service

Comment: S, Mo, Mi - This service is appropriate for children with social, behavioral, developmental and physical problems, where intensive evaluation and treatment can be provided, with the goal of the child's returning to his own home as quickly as possible.

48. Nursery School Programs - Mi

49. Preschool Programs

Comment: S, Mo, Mi - At least five recommendations relate to the need for preschool programs. The target age group here is approximately three to five years; younger children will be in day care programs. Most recommendations are concerned with the need for preschool programs for all children, especially those children from the culture of poverty for whom these programs are a critical necessity. Previous reference has been made regarding this urgent need under the Prevention component.

One of the recommendations suggests that preschool programs are necessary for the children of retarded parents, not only for the direct benefit to the child, but also for providing assistance to parents in working with their children.

The education planning group suggests the need for preschool programs for very young trainable children.

If the D.C. Public Schools plan for inclusion of the present preschool age groups comes through, the need for other agencies to step in will be obviated. However, if this is not the case, every avenue should be explored to expand present preschool programs, taking the children from the culture of poverty on a first priority basis.

50. Indian Guides and Similar Programs

Comment: Mo, Mi - These are suitable for the moderately and mildly retarded preschool child as they promote parent-child relationships.

51. Recreation Programs

Comment: S, Mo, Mi - Recreation programs for preschool children including individual--play, swimming, organized group activities, even day camping for the more mature child, are all important contributors to the child's development.

52. Adapted Physical Education

Comment: Mo, Mi - Physical education activities may be as important to the child's development as other programs.

53. Companionship Programs

Comment: Mo, Mi - A companionship program differs from child-sitting in that it has more of a child development purpose.

54. Home Curriculum

Comment: Mi - Providing an educational home curriculum which will help the mildly retarded child with his readiness for school entrance, can be important service.

55. Environmental Enrichment

Comment: Mi - This refers to opportunities for broader and fuller experience outside the home and neighborhood.

56. Special Child and Parent Centers

Comment: S, Mo, Mi - Specialized child and parent centers for the treatment of the more complex problems (physical, emotional and/or intellectual) at the earliest possible time of life will need to be established.

SCHOOL AGE LIFE STAGE

57. Day Care

Comment: P,S - It is suggested that each mental retardation center of the community health centers provide day care services for those children unable to function in a normal group situation.

58. Child Sitting

Comment: P,S Mo, Mi - See Comment 40

59. Homemaker Service

Comment: P,S Mo, Mi - See Comment 41

60. Foster Home Care

Comment: P,S Mo, Mi - See Comment 42

61. Small Group Homes

Comment: P,S Mo, Mi - See Comment 43

62. Short Stay Homes

Comment: P,S Mo, Mi - See Comment 44

63. Companionship Program

Comment: Mo, Mi - See Comment 53

64. Short Term Residential Treatment Service

Comment: S, Mo, Mi - See Comment 47

65. Education

S, Mo - a. Trainable Classes

Both Trainable and Educable Classes

Mi - b. Educable Classes

For the present, it is suggested that the public schools must be even better prepared than formerly, that the school teacher must be supported equally, if not to a greater extent by cooperating psychological and social services, and that education for adults can help effect the central role in the community that the schools must have. The need for a high level coordinating position for all special education programs has been referred to. The expansion of services of the curriculum department with articulation between the department and other agencies on curriculum; expansion of pupil personnel services; need for improved public information services; need for tution payments for children withdrawn from the public school program; need for a register of trainable children and youth; more adequate placement procedures with policies for transfer and withdrawal of children; need for lowering the age limit to admit very young trainable children and raising the limit to age 21; and providing for a 12 month program are referred to. The need for a department of special education at D.C. Teachers College and for establishing minimum educational standards for teachers is referred to. Other recommendations relate to D.C. School relationships with other agencies in developing programs of mutual concern, agencies such as the Departments of Recreation, Vocational Rehabilitation and Health.

66. Vocational Preparation

Comment: Mo, Mi:

There are several recommendations that relate to the area of vocationally related services. It is well to keep in mind that the D.C. Department of Vocational Rehabilitation will soon be publishing its report, District of Columbia State Plan for Workshops and Rehabilitation Facilities. This report will have a bearing on those recommendations relating to sheltered employment services, and parts of that plan can be incorporated, as appropriate, in the plan for comprehensive services to retarded persons and their families.

The recommendations which have been made thus far may be suggestive of the DVR plan. Activity Center programs should be related to vocational training programs with referrals and transfer an easy process. It is recognized that other agencies, especially the Department of Vocational Rehabilitation, must develop a relationship with the curriculum of the schools. The success enjoyed by the Eastern High School - DVR Project strongly supports such programs in every high school. It is recommended that appropriate audiologic evaluation should be a part of the total evaluation of vocational rehabilitation services. There is need for expansion of evaluation facilities for adults, and the vocational evaluation facilities need improvement as related to the five recommendations, which were made by Working Party on Vocationally Related Services.

Vocational training and sheltered employment service also should be improved, as recommended.

67. Personal Counselling

Comment: Mo, Mi: See Comment 101

68. Sheltered Workshops

Comment: Mo, Mi:

Some of the recommendations relate to sheltered workshops and sheltered employment opportunities. These call for: expansion of sheltered employment; efforts to eliminate tuition fees; closer collaboration between workshop programs; closer collaboration with the business community to explore new areas of subcontract work; establishing a relationship with the Regional Research Institute at the University of Maryland; a re-examination and re-definition, if necessary, of workshop roles and functions; and consideration by specialized workshops of the pros and cons of becoming multi-disability shops.

69. Recreation and Camping Programs

Comment: S, Mo, Mi:

There are several recommendations which have a bearing on recreation and group activities for retarded persons. If the schools assumed responsibility for preschool programs for trainable children, then the Recreation Department could turn more of its attention to serving other age groups, since its primary service, at present, is to some 50 preschool trainable children. In addition, if the schools provided a 12-month program for trainable children, as recommended in 21, the Recreation Department and others providing summer recreation and camping programs could concentrate on other groups of retarded persons needing summer programs.

The D.C. Recreation Department had taken steps to implement several of the recommendations. This summer, the Department is offering joint training programs for recreation and camp personnel. The Department was recently host to about 30 staff members from the Metropolitan area for a one day seminar focusing on summer programs for retarded persons; and has made a beginning on a joint project with the schools.

Certain recommendations have been absorbed in the component of the plan recommending a Structure for Coordination of Certain Selected Activities and Planning.

Further implementation of the recommendations will require much greater support of the Recreation Department budget requests than has been enjoyed in the past. The Department's plans to serve retarded persons through specialized services or as a part of the generic services to everyone, using special personnel, have been seriously hampered in the past. The joint project with the D.C. Schools, the development of the Lincoln Center plans serving larger numbers of retarded children, youth and adults in specialized ways will require a greater outlay of funds.

It is to be hoped that other agencies, such as the neighborhood and settlement houses, will attempt some group work with retarded persons in the future, and that youth serving groups will organize more such groups for retarded youth.

70. Youth Serving Groups

Comment: S, Mo, Mi:

Youth serving groups include Cub Scouts, Boy Scouts, Brownies, Girl Scouts, Camp Fire Girls, 4-H Clubs, Adventure Guides and Clubs or Canteens.

71. Adapted Physical Education Program

Comment: S, Mo, Mi:

Adapted physical education programs should be an important component of many recreation and camping programs, as well as of the education curriculum.

72. Environment Enrichment

Comment: Mi: See Comment 55

POST-SCHOOL LIFE STAGE

73. Activity Center Programs

Comment: P,S Mo:

It is suggested that Activity Center Programs for retarded youth and adults be a continuing responsibility of the Area Health Centers, as part of the mental retardation component of each center.

It is recommended that funds be budgeted by the Health Department to take care of this need in temporary locations, pending construction of the Area Health Centers.

It is also recommended that at the appropriate time, a Committee be organized, consisting of representatives from the D.C. Schools, those agencies operating sheltered workshops, those agencies operating activity center programs and other appropriate persons, to develop guidelines for referral and transfer of retarded persons from one facility to another.

74. Companionship Program

Comment:

There are many older youth and adults who could benefit from a "companionship" program while they are not involved in other activity--a program with implications for social development, companionship and relief of parents.

75. Homemaker Service

Comment: P,S Mo: See Comment 41

76. Family Care Homes and Boarding Homes

Comment: P,S Mo, Mi:

It is recognized that there are a number of retarded adults who are either living in their own homes or in residential facilities, who could live more appropriately in the small group homes or boarding homes, if they were available. As one of the recommendations suggests, these adults who require varying degrees of supervision, with the goal of increasing independence for each person. The costs of care for residents of the District Training School is approximately $9.75 per day, which is close to the average cost of private residential care. Economically, a boarding home program could be developed for much less; the costs might even be further reduced by charges to each adult according to his earnings.

It is recommended that immediate steps be taken to implement this recommendation. It seems logical that the agency having responsibility for residential care of most retarded persons, the Welfare Department, would be the most likely to have responsibility for such a program. The number of boarding homes eventually developed would be dictated by experience, but taking full advantage of this program will maximize the possibilities for growth and independence of many retarded adults - one of our major goals for retarded persons.

77. Half-way Houses

Comment: Mo, Mi:

One recommendation suggests that the number of halfway programs be increased to eight. The present halfway house, operated by the Department of Vocational Rehabilitation, is serving 10 men at a time. These men are former residents of the District Training School, and are taking this "half-step" to more independent living in the community. The proposal opens the doors to females as well as males, and also suggests that a person be able to enter a half-way house directly from the community rather than going to the residential facility. Since the Department of Vocational Rehabilitation operates the present facility, this seems to be a recommendation for that agency, although it has implications for the Welfare Department program at the District Training School.

78. Nursing Homes, Rest Homes and Infirmaries

Comment: Mo, Mi:

For some older retarded persons, nursing homes, rest homes or infirmaries will serve their needs best.

79. Short Stay Homes

Comment: P,S Mo:

Some adults will require facilities where they can live on a temporary basis, until they can return home.

80. Sheltered Workshops and Sheltered Employment

Comment: Mo, Mi: See Comment 66 and 68

81. Training for Employment

Comment: Mo, Mi: See Comment 66 and 68

82. Employment and Follow-up Services

Comment: Mo, Mi:

Several recommendations relate to the role of the employer, or the involvement of U.S. Employment Services. No recommendations have been made yet by our job development and placement activities Committee, which will necessarily involve employers to a large degree.

83. Recreation and Leisure Time Activity

Comment: Mo, Mi: See Comment 69

Recognition of the vital role that employers can play is clearly brought out in one recommendation which deals with on-the-job evaluation. The employer is truly a partner in reaching the ultimate goal for nearly all retarded persons - the placement in satisfying and productive employment - a goal toward which most all other services are, at least in part, directed.

84. Adult Education

Comment: Mo, Mi:

Adult education or continuing education should be provided the retarded person who has left school, just as it might be provided the rest of the community.

85. Personal Counselling Around Adult Problems

Comment: Mo, Mi:

Retarded adults need counselling services around their individual needs. It may be marriage counselling, vocational counselling, home management, management of finances, counselling regarding child rearing, or living arrangements, or other adult problems and concerns.

SUPPORTIVE SERVICE NEEDS

86. Research

Comment:

Seven recommendations point up the need for research. One suggests that nurses participate more in research projects; another suggests that research is needed in the ways religious concepts and value are imparted to the retarded person; a third recommends a study of training programs needed to rehabilitate the retarded offender; a fourth states that research is needed in ways to utilize the "wisdom of the client" - what he knows and feels about himself, and about the efficacy of services offered to him.

A strong recommendation was made that concurrent research studies be considered an essential element of every program design and states that epidemiological data are incomplete. Demographic data need to be brought up-to-date. More complete knowledge of the "culture of the poor" is required for more effective interventions to minimize pathologic efforts.

The relative efficacy of various training programs for staff, of the different programs of intervention should be determined at the earliest possible moment. The immediate and long-range economy, including a strong research arm in every programmatic phase, will prove self-evident.

The other recommendations suggest that where institutions of higher learning have separate departments of special education and speech pathology and audiology or special education, physical education and/or recreation, they sponsor joint projects or cooperate in research.

87. Information and Referral Services

Comment:

One of the keys to getting those in need of service and the resources together is a quality information and referral service. At the present time, every agency offers such a service to the best of its ability. A centralized service is needed to provide a quality service which all agencies will recognize and be willing to be involved in supplying and receiving information and referrals.

It is recommended that the information and referral service be a part of a structure for coordination of certain selected activities and planning. There would be obvious advantages and there would be a higher quality of service if it were closely related to a number of functions which relate to coordination and planning. Special staff would be needed to handle this service, which should be more than a telephone information and referral service. The principle of follow-up on all referrals should be built in the service to maintain a higher quality and more sensitive service.

88. Personnel Needs

Comment:

Approximately one-fourth of the recommendations deal

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with some aspect of personnel needs. Most are specific with regard to preparation needs, although some deal with recruitment, placement, etc. Recommendations, while mostly related to professionally trained persons, also recognize the role of non-professional staff and volunteers. Several planning groups will make additional recommendations in the future, but those cited above came from eleven different groups.

The director of the Division of Mental Retardation, Social Rehabilitation Services (HEW), made as one of his points, in his 6-point program for developing model community services for the mentally retarded, that there should be "Provisions of basic training in mental retardation for every health worker", and goes on to say that, "every personal service worker should have such training". He believes that with such training generic agencies will be able and more willing to open their doors to the retarded, and that having gained some basic knowledge, the worker could identify most retarded people, be able to handle basic questions, relate specific services to the needs of the retarded person in a more meaningful way, and make logical referrals at appropriate times.

Sixteen of the recommendations make specific references to the need for in-service education, workshops, seminars, training institutes, post-graduate courses, staff development programs, refresher courses, etc., which recognize the needs that workers have for not only basic training, but also for keeping abreast of the latest developments in mental retardation.

Nineteen recommendations relate to minimum course sequences; curriculum content of various schools; the need for maximum opportunities for field experiences; suggestions to a local college regarding the need for a department of special education; the need for some of the separate departments, such as special education, speech pathology, audiology, physical education and recreation, working together in joint endeavors, such as training, research, education, and sharing in other ways; and working with residential facilities for the retarded for use as training centers for students.

One recommendation deals with the need for an in-depth study of problems of recruiting and maintaining staff at the District Training School. Others are concerned with the employment of youth and using them as volunteers; another relates to the need for a coordinating mechanism for recruitment, training and placement of volunteers. One recommendation relates to the recruitment of foster parents, and another recognizes the need for using non-professional staff. One cites the need for expansion of pupil personnel services, and the hiring of public information staff for the public schools.

Several recommendations are concerned with the role which the consortium of universities might play in collaborative training endeavors. One recommendation specifically refers to the need for active participation and support of the Georgetown University - Affiliated Facility for the mentally retarded.

One recommendation concerns the need for trained child care workers and neighborhood aides.

Another recommendation concerns the need for research on the relative efficacy of various training programs for staff and the efficacy of different programs of intervention.

A number of the planning groups have moved ahead with implementation of some of their recommendations in this area. Four institutes or conferences have been held relating to religious needs, nursing services, and recreation; the teacher preparation committee has held four conferences involving D.C., Maryland and Virginia people; the social work committee had a group meeting with Department of Welfare staff to discuss staff training; and in some instances, key people have begun meeting on curriculum needs.

The task force on personnel needs suggests that a seminar on personnel needs be held involving all disciplines including those related to training and preparation.

89. Public Education

Comment:

One of the original charges to the Mental Retardation Committee prior to beginning the planning efforts was "stimulation and development of greater public awareness of the mental retardation problem and the need for combating it". The charge to each task force was a repetition of this charge: "To develop public awareness of mental retardation problems and the need for combating it".

There were a few activities during the first 18 months that, in a small way, followed through on these charges. However, it was not until the public information committee was formed in recent months that a systematic approach was developed. Several recommendations have been made regarding public information needs, but the recommendations of the public information committee provides direction for a well-rounded approach.

The committee activities have provided some beginnings for many of the components of the recommendations and, as has been mentioned, the directory of services is well on its way to completion. There has been either involvement on the committees or contacts made with local press, radio and television and an interest in helping that is refreshing. The assistance furnished with "The Chairman's Report" is looked on as a forerunner of a periodical for broader distribution.

The speakers bureau has been organized and has already filled at least one engagement. Liaison has been set up between the committee and those working on the directory of services.

Although this group started very slowly and later than had been hoped in carrying out charges made to the planning people, there is now a good beginning and is prepared to move forward as rapidly as possible. Information to and education of the many publics is basic to the understanding and subsequent support which will be needed in the future. This program must move forward as quickly as possible.

90. Religion

Comment: See Comment 103

91. Transportation

Comment:

One of the major barriers to serving retarded persons and their families is the lack of transportation. Recommendations call for a thorough study of present solutions. Current and projected needs will provide a basis for future action to solve this most difficult problem for many agencies.

92. Registry

Comment:

Five recommendations have been made which suggest the need for a central registry. One relates only to trainable children and youth, while the others suggest a registry for all retarded persons, and one additional recommendation suggests that it be metropolitan in scope.

It has been recognized that there would be some problems in establishing a registry. It was recommended that ways and means be explored for establishing a registry with proper safeguards.

Earlier it was suggested that when the Life Experience Coordinator approach is used broadly enough, the central files and individual files would have great practical value, rather than a theoretical value, for serving the retarded person and his family. It is recommended that any plans for a registry be delayed until a decision has been reached about implementing the Life Experience Coordinator concept, because the central files, using this concept, might well satisfy most or all of the reasons for recommending a registry.

93. Social Action

Comment:

The Service Council, referred to later in this chapter, is presently composed of four sections, the first of which is made up of representatives of groups and organizations having a special interest in mental retardation, with parents of retarded children playing a key role.

Section II is composed of representatives from service and fraternal groups and organizations: such as, Civitan, Jay-cees, Junior League, Kiwanis, Ki-Wives, Lions, Optimist, Masonic Orders, Orders of Eastern Star, Toast-masters, Washington Round Table, Knights of Columbus, and Shriners and others. Many of these clubs and organizations have been and are presently supporters of projects and programs serving retarded persons; some have mental retardation as a key project and as part of a national movement. The Section II meetings thus far have pointed up the tremendous potential of member groups for understanding and service. The development of plans for supporting identified service needs and projects has already begun, with coordination among the groups a prime consideration.

Section III is composed of representatives from such groups as religious, labor, veterans, civic and citizen associations, as well as others, who will provide an even broader base of community understanding of mental retardation as well as support of the many areas of need.

Section IV is composed of high school and college age youth in the community. Some of the objectives are education of youth as relates to mental retardation; with greater understanding, opening up opportunities for recruitment of youth into the field of mental retardation; and involving youth as volunteers in specific programs and projects.

Although the Service Council is in the early stages of development, it is apparent to those participating that this is a social invention with enormous potential for promotion of community education and understanding and subsequent service in many ways. The need for involvement of the community in social action programs on behalf of mental retardation can be at least partially fulfilled through the Council.

There has been steady progress over the past few months in organizing the Council. The staff time requirements for developing and serving these four sections are very demanding. It is recommended that special funds be sought to hire another staff person, on a full or part-time basis, to work with development of the Section IV (youth).

94. Directory of Services

Comment:

Many planning groups recognized that a vital tool in serving retarded persons and their families is a current directory of those services which are available. The committee has been most fortunate to have two persons during the past several months developing a directory as a volunteer service. The scope is broader than mental retardation and wider than D.C. and will include information on services for all handicapped persons for the metropolitan area. One volunteer has been giving over-all direction and leadership to this project, which is being coordinated with the planning process.

95. The Law

Comment:

The task force on law studied the D.C. Code with reference to law pertaining to mental retardation. It has since awaited recommendations whose implementation might require changes in the law.

It should be noted that excellent work has been done by the committee on laws pertaining to mental disorders of The Judicial Conference of the D.C. Circuit. Their significant project on "Legislative Specifications for Residential Care of the Mentally Retarded", will provide a basis for some much needed changes.

96. Financial Assistance

Comment:

Many families require financial assistance because of the unusual demands of care and treatment, such as foster home care, private day school or other day programs, medical costs and other costs related to multiple-handicapping conditions. The chronic nature of the condition adds to the financial burden.

97. Medical Care and Treatment

Comment:

The Committee on Medical Care has developed some preliminary recommendations, none of which have been discussed by the Mental Retardation Committee. However, the committees are concerned with the philosophy and practice of medical care for retarded persons; the need for short term residential placement for children with social, behavioral, developmental and physical problems for intensive evaluation and treatment; the need for good information and referral services; and the preparation of physicians as relates to mental redation. The planning group concerned with identification and diagnosis developed guidelines for the physician and recommendations relating to health supervision during the early years. These recommendations relate to medical needs of all children, some parts of which have implication for prevention of mental retardation.

98. Dental Care and Treatment

Comment:

Some of the nine recommendations have implications for the D.C. Department of Health and others relate to the D.C. Dental Society and the D.C. Public Schools. There are several that relate to the role of community dentists in serving retarded and handicapped persons, their need for post-graduate courses and other educational opportunities, and their availability for treatment.

99. Public and Private Residential Care

Comment:

Many of the recommendations have a bearing on residential care. Some are suggestive of new roles for educators, schools of social work and others as they relate to the needs of residents. The need for a facility for older offenders, the relationship between the schools of social work and the institutions, the need to study problems of recruitment and maintenance of staff, the relationship of institution programs to the development of more half-way houses, boarding homes for adults and foster homes for children are included.

100. Life Consultation Services

Comments:

The Life Experience Coordinator (or Case Manager or Development Counselor) concept satisfies, in part, the recommendation made by the President's Panel on Mental Retardation: "There should be available in every community a fixed point of referral and information which provides a life consultation service for the retarded".

A job description follows for the Life Experience Coordinator, who would work with these children, youth, and adults with development problems or with a potential for development problems:

a. Keeps, develops and interprets cumulative record on child and adult; gathers material for record from agencies serving the child; has own input into record regarding contacts with child and family;

b. Brings knowledge and information from the cumulative record to any service, e.g., child health clinic, pre-school and school programs, for correct placement and interpretation to staff of agency, such as physicians, nurses, pupil personnel workers, principals, supervisors, teachers (for those who cannot be served by the school, there is liaison with other services, such as day care, activity programs, District Training School, etc., maintaining a long-range interest);

c. Strengthens parent-school and parent-agency relationships - through interpretation, encouragement, introduction to key people, bridging the gap to the unknown, supporting the parents' outreach and participation in other ways, so that the parent makes better use of school and agency program (this is a major key to child's improvement);

d. Supports and strengthens parents involvement in child's learning process: suggests that parents become related to in-school program - assists child with home training, acts as parent aide for pre-school program, etc.;

e. Develops liaison with other agencies and hospitals; supporting family in use of services offered by agencies and hospitals - working with any agency in the community which has the common goal of service to the retarded person for his maximum development, such as health, welfare, education, recreation, rehabilitation, employment, agencies and hospitals for physical, mental, and social needs;

f. Provides continuity of care for retarded persons separated from their families; remains active with retarded person and his family. While separated (retarded persons may be in foster home, boarding home, District Training School, Cedar Knoll, Maple Glen, Lorton Youth Center, reformatory, St. Elizabeths, Junior Village, Receiving Home, private school for the retarded, facility for disturbed child or adult, facility for children with other special needs - deaf, blind, etc.);

While remaining active with retarded person and family, works with others toward other plans for retarded persons, such as return to family, placement in another home or facility;

g. Works with youth as he emerges into adulthood, making the best use of appropriate services, such as; activity center programs, sheltered workshops and training programs, Department of Vocational Rehabilitation services, employment services - through USES and employers, continuing adult education; notes need for leisure time, recreation activities relating to group work and recreation services; counsels with him regarding personal problems;

h. Develops liaison with supportive services within the schools (often there have been resources in the school which teachers could have used, but did not, for one reason or another - most likely a lack of time);

i. Establishes a relationship with research and training programs, providing a longitudinal approach which offers unique opportunities, as one follows a child's development into post-school years, for feedback into the curriculum of the schools or the programs of other agencies, such as evaluation services, recreation, health, rehabilitation, employment, etc.; the kind of information which might help toward improvement of these programs can be a major factor in more realistic programming; efficiency and effectiveness of services may well be improved by such a longitudinal approach.

The Life Experience Coordinator may enter the picture as soon as identification is made of a special developmental problem or suspected developmental problem, e.g., through the MIC Project - high risk cases - or identification at or near birth of babies who will not develop normally, such as mongoloid babies, or where the potential is great for deprivation. It would be ideal if the Life Experience Coordinator could provide continuing supportive services to the family over the early crucial years, when the child and his family are now mostly neglected, and where continuity of care will reap the greatest dividends.

Another advantage of the Life Experience Coordinator entering early would be avoidance of the labeling and categorizing which adds to special problems faced by the child and his family. It is important to keep the reason for service simple, such as the child who needs or potentially needs help with development or learning, etc.

When offered broadly enough, the following services are naturally concomitants of the Life Experience Coordinator service:

1. Information and referral services;

2. Developing and maintaining a central file that has great practical, rather than theoretical value - for serving the child and his family;

3. Opportunities for staff training and development;

4. Opportunities for staff research and special studies;

5. In working with generic agencies, helps the generic agency worker become better informed about his client, and then assumes a more meaningful role in serving the retarded person and his family, for example, the public assistance worker, or the public health nurse, may not be serving the client well out of ignorance, fear, etc., which the Life Experience Coordinator can help dispel, hence bringing the generic agency workers into more meaningful, satisfying roles.

Using the Life Experience Coordinator concept would satisfy, at least in part, many of the recommendations. The continuing supportive services of a guardianship program suggested; the continuing supportive services suggested for the retarded offender; the development of a prophylactic-therapeutic program in collaboration with the parents, after diagnostic approaches to babies and families; the support of the teacher in her educational tasks, by seeing to it that the child's basic needs are met by other agencies; acting on behalf of society as a supporting extended family until it is strong enough to stand on its own; all could be satisfied by a quality service as suggested by this approach.

The Life Experience Coordinator, Case Manager or Development Counselor approach could carry on some of the functioning suggested by a case registry. It could strengthen the information follow-up of referral services, and contribute to the ongoing process of keeping a directory of services current.

This person would be available and helpful to the placement and admissions, transfer and withdrawal processes and could help with identification and referral of pre-school children to appropriate programs and the appropriate time for referral and transfer of the trainable youth to the sheltered workshop, activity program, or other appropriate service. This counselling person represents the essence of continuity of care utilizing knowledge of the family and individual for appropriate and timely referrals, and use of other resources.

The Life Experience Coordinator may contribute through the continuing, long-range contact to the case finding process, counselling regarding adaptation of birth control programs, the development of and appropriate use of evaluation services, the expansion of non-professional and volunteer services, and the best use of the "wisdom of the client". Because of his intimate relationship with the retarded person and his family, he will be able to contribute to such services as a cooperative project to encourage improvement in homemaking skills among retarded women; the use of groups and group techniques; the development of nursery and kindergarten programs; the hospital committee; the education program during the pregnancy and interconceptional periods; the identification of retarded persons and their families in the various religious congregations, thus helping a major source of support become active; contribute to the ongoing process of study, diagnosis, prognosis and treatment; help with the study of the retarded offender; and help with progressive steps of freedom in a treatment program for older offenders. This Development Counselor will be in a position to judge the degree of passivity or initiative of the family, the necessity for intervening for the family, and a need for more accessible services through creative approaches; he will also be available for working with specialized child and parent centers for treatment of the more complex problems.

The Life Experience Coordinator can also contribute to research studies, and would be in a favorable position to evaluate the relative efficacy of different programs of intervention. He will, with his knowledge of the needs of the child, youth or adult who is retarded and of his family, be able to make appropriate referrals and recommendations for a variety of services, such as youth serving groups.

Obviously, one Life Experience Coordinator could serve only a limited number of families at any one time. Would 60 be a reasonable caseload, assuming that only a fraction would require intensive work during any given week or month? It is suggested that 60 might be a theoretical optimum caseload until experience dictates that it should be increased or decreased.

The number of this kind of staff required would depend on how one used these Development Counselors; whether all high risk infants might be included or only selected cases; whether all families who needs a prophylactic-therapeutic program were included or only selected families; whether all children with learning problems or potential for learning problems were included or again, only selected cases; whether all adults would be included or just selected cases. It seems that at least 100 and perhaps several hundred such persons would be needed to provide optimum service. Recognizing the very real problems of funding and staffing, it is suggested that a beginning be made with 20 development counselors, 4 supervisors (1 supervisor to 5 counselors) and 1 director-coordinator. This would provide sufficient numbers to make some impact and provide enough experience during the first year or so to provide a foundation for long-range plans.

It is further suggested that the Life Experience Coordinator or Development Counselor position might be filled with persons who have less than 4 years of college work. High school or 2 years of college might be enough academic background on which to build a training program for this particular work. Excellent supervision at all levels would be necessary, of course.

Because of the longitudinal approach to serving this group of people, it is suggested that each Counselor would carry a mixed caseload, ranging in age from infancy through adulthood. A theoretical age breakdown might be as follows:

Preschool ages	- 20	
Elementary ages	- 20	(through 6th grade)
Junior and Senior High	- 10	
Post-school ages	- 10	
Total	60	

Each generic agency would carry its own cadre of Life Experience Coordinators who would follow assigned families for life.

101. Counselling for Retarded Person and Family

Comment: Counselling services are needed by parents of retarded children, by other members of the family, and by the retarded young person himself. The retarded youth who becomes the retarded adult may require counselling services, especially if he becomes a parent himself.

Any agency which offers a service to the community, and almost every professional person is called upon at one time or another to counsel with parents of retarded children. This holds true especially of those related to specialized services to retarded persons and their families. The following observations might be useful in discussing this area of need:

a. Counselling in this area of human concern, to be adequate, must be recognize as ongoing and time-consuming, and must be adequately budgeted for;

b. Most counselling efforts are inadequate with regard to quantity of service and there is little continuity of care offered, largely because of inadequate budget, so that follow-up contacts are made almost exclusively on the initiative of the parent;

c. In most instances, services now offered are pretty much superficial, with little chance for depth of experience and quality of services;

d. Services to retarded children must be family-centered rather than child-centered, as is so often the case. One cannot help the retarded child and youth, without working with his family. It is very rare that siblings and other relatives are included in counselling services;

e. Some of the counsel and advice given parents is not only inadequate, but damaging;

f. The quantity and quality of counselling has generally been so poor, that many, if not most, parents carry a burden for many years that would have been somewhat relieved by good counselling services;

g. When parents of retarded children have received adequate counselling and other services, they in turn, become good potential sources of help to other parents;

h. The parent who is retarded himself has need for supportive services, which are important to the development of his children;

Several of the recommendations for action will have a bearing on the adequacy of counselling services. The Life Experience Coordinator who shares in the counselling function can do much to enhance the counselling role of all others who have contact with family or the retarded person. The basic training suggested for each personal service worker and the specialist in mental retardation for each generic agency would help to improve the quality of service. The recommendations relating to preparation of professional persons, both in their academic preparation and in staff development and continuing education programs will also help. There should be greater use made of group counselling approaches with retarded children and youth, retarded adults, parents of retarded children, siblings and other relatives of the retarded person. A careful look at all types of counselling presently being offered is indicated.

102. Parent Involvement:

Comment: Since the late 1940's, parents of retarded children have played an increasingly important role in serving the retarded person and his family. The growth of the parent movement has spearheaded the whole mental retardation movement, so that today, some 15 to 20 years later, almost undreamed of progress has been made locally, state-wide and nationally. The "parents' groups" which have more and more involved others who are not parents of retarded children have led the way in many communities throughout the nation in demonstrating what could be done and that retarded persons could be helped. These have been action groups which have stimulated other agencies to assume their rightful responsibilities and they have supported those efforts and cooperated in many ways.

The work of the parents has done much to change the prevailing attitudes and the climate of the country toward mental retardation. They have made it possible for others to join in, to speak out, to lead a movement in Congress, or take action on the highest level possible - the presidency and the vice-presidency.

Parents have therefore played most important roles in this movement. However, there are two areas of service provided by and through associations for retarded children and other parent groups which are not often recognized. These are the parent-to-parent relationships and the opportunities through group activities to do something constructive on behalf of mental retardation.

The parent-to-parent relationship is unique to the parent group and is not fostered nor available through other agencies or organizations. It may be informal or in some instances formalized so that certain parents are selected and prepared to counsel with other parents of retarded children. Whether casual or formal, at association meetings or in homes, the parent of the retarded child who has matured in his relationship to his child and who is concerned about the needs of the field of mental retardation as a whole has a potential for support of other parents as they progress with their relationship to mental retardation. Obviously not every parent can help others, but more conscious efforts need to be made to make use of this potential service.

Parents quite often feel helpless and hopeless with respect to their own child and see little possibility for constructive activity. Association or parent groups do offer some opportunities for some parents to become involved in constructive action. This may not, and quite often does not, have a direct relationship to that parent's child needs, but rather has broader implications for the needs of all mentally retarded persons and their families. Through board and committee activity, through volunteer work, through fund raising activities, and through social action projects, parents have contributed greatly to the whole movement and incidentally, to their own mental health in the process. Parents have much more potential than is presently being used, and a careful look at the possibilities for using this potential is needed. An attempt is being made through the Service Council, to make use of the potential which parents have.

Of the 23 members groups of Section I of the Service Council, 8 are parent groups whose primary concern is mental retardation; 9 are groups with a major concern for mental retardation as well as a concern for other handicapping conditions, 6 have a major concern for other special needs, but are also concerned about the area of mental retardation. It is evident that there is a potential for coordinated efforts of the members of this Section I which did not exist prior to the development of the Service Council. It is believed that this social mechanism will provide the opportunities for mutual support of one another's goals, help toward coordination of development of new services, make possible an overview of needs for services of members groups, and make possible collective action in supporting budgetary and legislative requests. Section I, in its developing relationships with the other 3 Sections, will bring its long history of involvement with mental retardation to bear in stimulating and inspiring others to action on behalf of retarded persons and their families. It is to be hoped that new and creative ways will be explored to make use of the potential which these groups have to offer. We have a unique opportunity offered us which we need to pursue in depth.

103. Religious Education

Comment: These recommendations are a direct challenge to religious bodies to examine their positions and their responsibilities with respect to some fundamental questions about the place of retarded persons in the religious community.

Several recommendations have been implemented in beginning ways. The one-day conference on meeting the religious needs of retarded persons and their families, for clergy and religious educators in particular is an example of this. A committee was organized relating to this need. One recommendation in this area has been implemented in a beginning way, through some interfaith training programs for religious educators.

104. Hearing and Speech Services

Comment: There were 12 recommendations made by the speech and hearing planning group. Several deal with serious omissions of audiometric screening or speech pathologists - audiologists from diagnostic programs.

One recommendation is for compulsory hearing tests to be given children before they enter school; another calls for further development of speech pathology and audiology services in existing and future facilities for the retarded.

Several recommendations suggest that where universities and colleges have separate departments of special education and speech pathology and audiology, they explore the possibilities for joint training, joint-projects, and appropriate ways of referring patients, sharing caseloads and exchange of teacher's aides as relates to mental retardation.

Furthermore, where one or another program is not offered, it is recommended that a consortium arrangement be made, so that students could take courses not offered in the resident University. In addition, post-graduate courses for speech pathologists and audiologists are called for.

105. Identification - Diagnosis - and Evaluation

Comment: The President's Panel Report has this to say on the subject:

"Because adequate training and care are dependent upon early detection and evaluation, every child should receive continuous child health supervision. Every child should be examined for possible intellectual deviations; screening tests for the early detection of abnormalities should be established as part of the regular routine services of well-baby and other child health clinics.

The importance of an adequate evaluation early in the life of every child suspected of mental retardation cannot be over-estimated. Decisions based on erroneous expectations as to the child's capacity can lead to chronic failure with resulting emotional handicaps. Unfortunately, even among professional personnel, neither this nor the advantages of specialized treatment and care during infancy and childhood is fully appreciated. The responsibility for early identification of the mentally retarded child rests with the members of professions who see children at an early age, including the family physician, the public health nurse, or the child welfare worker. Diagnostic and treatment facilities, and social and health agencies share this responsibility along with nursery schools and day care centers. Indeed, every individual and organization dealing with the preschool child in a professional capacity is involved."

The planning groups concerned with identification and diagnosis developed nine recommendations, outlining pathways by which retarded persons in the community are identified and diagnosed. They suggested guidelines for the doctor and mother for identification in the nursery and in early infancy; guidelines for identification of infants and toddlers under two years of age; guidelines for identification and diagnosis of mental retardation in the preschool child (2-5 years of age), and a screening program for the school age child.

References are made to the need for improved diagnostic and evaluation procedures in at least 13 other recommendations.

The following observations are appropriate:

a. Present identification, diagnostic and evaluation procedures and services are not adequate to meet today's needs;

b. There is need for improved communication among the agencies Providing diagnostic and evaluation services and between generic and specialized agencies;

c. The evaluation role of certain professional groups has been minimized in the past, e.g., the role of teachers as evaluator;

d. The lack of recognition of diagnosis and evaluation as a continuing process;

e. Evaluation service for adults has been only recently implemented, since the concentration has been primarily on children.

Considering the above, it is recommended that as soon as possible, a seminar or conference of 3 to 5 days duration be held for purposes of considering:

a. All current identification, diagnostic and evaluation procedures and services;

b. A review of latest information, techniques, etc., as relates to better programming;

c. Recommendations regarding new and improved ways of identifying, diagnosing, and evaluating persons who are retarded, potentially retarded or suspected of being retarded;

d. Plans for implementing recommendations outlining the beginning steps and the long-range aspects of translating recommendations into services.

All staff from specialized agencies serving the retarded would be involved. In addition, appropriate personnel from generic health, education, recreation, employment, rehabilitation, correction and welfare agencies (private and public), hospitals and institutions of higher learning would be invited to participate.

VI. COMMUNITY MENTAL RETARDATION CENTERS

Following are the suggested roles and functions of the four centers anticipated in the future.

1. They are part of community health centers and are interrelated with public health and mental health services;

2. They have coordinating responsibility for program purposes, bringing into partnership health, welfare, education, recreation, rehabilitation and employment agencies and institutions (public and private) hospitals, universities, and colleges and other institutions serving retarded persons;

3. They provide counselling services as relates to a variety of services;

    a. for retarded youth and adults and
    b. for parents and families of retarded persons;

4. They offer continuity of care through a longitudinal approach, following a child into adulthood;

5. They provide specific services:

    a. Complete diagnostic and evaluation services, including inpatient service for evaluation purposes; also, will provide for evaluation services for retarded offenders to insure more appropriate placement plans;

    b. Day care with each mental retardation center providing this program for children who need a specialized group because they are unable to function in a normal group situation;

    c. Activity center programs for youth and adults, established to supplement such existing private agency services for retarded persons 16 years and older who need the kind of service oriented toward promoting growth primarily in the area of social development, with these programs related to school and vocational training programs in such a way that cooperative transfer may be easily made, as appropriate, from one to the other (i.e. school to activity center or to sheltered workshop, or activity center to school or sheltered workshop, or sheltered workshop to school or activity center), and with education, rehabilitation, recreation and other personnel having a role to play in the development of such programs;

d. Short term residential care for emergency situations and to relieve families of care for brief periods;

e. Home training program, as part of counselling service for families;

f. Special education programs (through D.C. public schools) for any students in residence;

g. Recreation program (through D.C. Recreation Department) for those in residence or in day programs, as appropriate;

h. Psychiatric services for retarded person and his family, provided in conjunction with the mental health services available;

i. Complete medical care available, as needed;

j. Transportation services for those needing the services of the mental retardation center and unable to get there otherwise;

k. Research programs, as appropriate;

l. Training opportunities for professional and non-professional personnel; and

m. Other services provided as appropriate to developing programs, such as occupational therapy, speech therapy, and physical therapy.

6. The following activities and programs are suggested as responsibilities of a coordinating structure which would be stronger and provide better services, when many, if not all are included.

   a. Coordinating responsibility for bringing into partnership: health, welfare, recreation, education, rehabilitation, and employment agencies and institutions; hospitals, universities and colleges; religious bodies; children and youth serving agencies and organizations, and the citizens of the community for purposes of planning comprehensive services for children, youth and adults who are retarded and their families;

b. Information and referral services;

c. Development of and keeping current a directory of services for handicapped persons;

d. Developing and maintaining a central registry of retarded children, youth and adults, as appropriate;

e. Conducting special studies as relate to planning;

f. Public information and education and action program through appropriate committees and Service Council activity;

g. Maintaining a central library of books, periodicals, audio visual aids, etc., for all persons (lay and professional) with an interest in mental retardation;

h. Study and coordinate planning and programming for transportation needs;

i. Coordinate activities as relate to volunteer work - recruitment, training and placement;

j. Serve as a clearing house for employment in field of mental retardation;

k. Coordinate activities as relate to youth services and to the Youth Section development of the Service Council, including both volunteer and paid work in the field of mental retardation;

l. Coordinate education and training opportunities - of in-service, institute, conference and seminar nature.

m. Development of standards of all variety of services for retarded persons and their families;

n. Using standards as guides, evaluating the services being offered;

o. If appropriate, through the social mechanism of the Life Experience Coordinator, providing counselling service on a long-range basis;

p. If appropriate, coordinating research efforts on mental retardation among the agencies and institutions serving D.C.

Securing the proper "continuum of care" for each retarded person at successive life stages requires expert attention to planning on a long-range basis. The law provides that in our society parents serve as the primary coordinators on behalf of their children. Education "for citizenship" includes learning to utilize the resources for education, health safety and the like on behalf of oneself and one's family. A citizen who is less than expert at this can usually negotiate a path to these resources to meet ordinary needs, with the informal advice of neighbors and relations. It is when the ordinary individual has extraordinary needs that self-coordination-self guidance through the maze of community services may tax his capabilities. This is even more true when the individual's ability for self-management is impaired.

Coordination of services for the individual retardate begins therefore with a capable parent or other adult willing, able, and obligated to concern himself with the retardate's continuing and changing needs. But the most intelligent and dutiful parent or guardian, let alone the retarded adult, cannot be expected to have adequate knowledge of the extraordinary resources necessary to secure the requisite "continuum of care" for the retarded person. Furthermore, the lifetime duration of a mental handicap - especially in those with more severe impairment of adaptive behavior - precludes the availability of the natural parent or guardian for the retardate who survives to the expected 'three score and ten'.

Experience has shown that barriers or breaks in the "continuum of care" often arise at points where the family of the retardate must find a new service and establish a relationship with it. At this point, a 'home base', a familiar face, a person to whom one does not have to rehearse once again one's 'history', a person known and trusted from past experience, can make the difference between a referral which is accepted and one which is not." (Report to the President, National Action to Combat Mental Retardation, pages 91 and 92, October, 1962).

COMMUNITY MENTAL RETARDATION CENTERS (Continued)

Are there alternatives for coordinating services needed by retarded persons? There has been a tendency to simplify the problem and thus to simplify the solution to the needs of the retarded person and his family. But it is not a simple problem - rather a very complex concern to many agencies - a concern for not only the retarded person but his family as well.

It is a long-range chronic, lifetime situation for many retarded persons, differentiating it from other temporary diseases and conditions, and this calls for a longitudinal approach and perspective in order to render effective service.

It is a continuous condition that does not end with the school day, or the activity program or the workday. It is always with the family and the retarded person, often requiring multiple services from a variety of sources, at any one time.

Agencies cannot work in isolation from one another and serve the retarded person and his family well. There must be communication with one another, there must be coordination and collaboration. There is a desperate need for everyone concerned with the mentally retarded person to have the perspective in serving him. The educator needs to know what the future holds for his retarded pupil in order to plan his curriculum; the recreator and all others need to know how their roles relate to the services of others and what they can do to influence the retarded person's future.

The community cannot afford a system of discontinuous, disconnected, fragmented, piecemeal service, which provides poor and inefficient benefit. There must be continuity provided that has a long-range, continuous concern.

VII. IMPLEMENTATION

It is clear that the task of implementing the recommendations of the Mental Retardation Committee is one of monumental proportions. The recommendations cover the entire spectrum of services to the mentally retarded; virtually every public agency and innumerable private organizations will have a major role in this operation. It becomes glaringly obvious that some form of city-wide coordination is necessary if any semblance of order is to be preserved in providing a unified program of service to the retarded. It is also rather evident that any attempt to focus the implementation process through the narrow lens of single agency responsibility will be of negligible value to a problem that is so broadly based. The wildly aimed "shotgun" approach, as a potential solution, that lies at the other end of the continuum is equally ineffective and results in more damage than good.

The realization of a compromise that will capitalize upon the strengths that exist and overcome the deficits, remains then, as our goal. Any compromise will result in some "loss" of component parts. However standing as a truism is the fact that "something must be given up if something is to be gained."

The recommendations and organizational structure to be described in the following paragraphs will attempt to present a mechanism that will allow for a reasonably rapid and hopefully comprehensive attempt to actualize the recommendations made by the Mental Retardation Committee. The solution to be offered will undoubtedly be inadequate to the problem in some ways. It is suggested however that the positive aspects far outweigh the negative factors.

There are two primary problems to be faced; the first is the establishment of a system of priorities that will allow for an ordered implementation of the recommendations. The second, the design of the coordinating and implementing mechanism.

The first problem can be most effectively resolved in the following manner. Inasmuch as the recommendations of the Mental Retardation Committee effect literally every public agency in the District of Columbia, it is suggested that the agencies themselves provide the hierarchical rankings of the recommendations related to their own areas of interest. Such a procedure has many advantages. It allows those who are most intimately concerned with the problem and best qualified to judge their own potential to serve as the primary architect of this design. It will also make possible the completion of a task that might ordinarily take an inordinate amount of time in a relatively short period of time. This recommendation has been put into operation and all involved agencies have been asked to submit their recommendations. These will be forthcoming in the very near future.

The second major problem to be faced is in reality two separate but of course intimately related problems. They are: who will do it and how? It has already been established that any effective attack upon the problems of mental retardation can be mounted only through the efforts of many different agencies and individuals. No one organization is capable of providing the comprehensive effort that is necessary. It therefore seems most logical that the instrument of service should continue to be the agencies already involved in this struggle.

The implementing tool may need honing, the machine may need lubrication, in some instances some repair may be necessary but the chest of tools that are available are basically very adequate for the task at hand. There does not appear to be any reason therefore to urge the establishment of a new administrative or service-oriented organization. The problem that has not been resolved, however, is one of how to achieve a reasonable orchestration of the various instruments playing in this symphony and how to achieve the direction that is necessary if we are all to stay in tune with each other.

Moving ahead on the assumption that no change in the current authority to act is either necessary or desirable, it is suggested that a high degree of coordination will be derived if easy and thorough communication between the various authorities could be established. Open and ongoing communication, is the key to the success of any effort to achieve coordination, regardless of what mechanism is utilized.

Recommended therefore, and enacted is the establishment of a committee representing each of the public agencies involved in providing service to the mentally retarded, as well as representation of the private sector through the Health and Welfare Council. This committee shall be composed of individuals who will be the "deputy" of the directors of the various agencies and will therefore have easy access to the head of the agency. This person will be in a position to influence the policy of the agency he represents. This committee will be The Mental Retardation Committee for the District of Columbia and will ultimately displace all other planning committees working in the area of mental retardation. This committee will substitute for the committee, task force or other groups that are established by the various agencies who have projects supported by federal funds and require "advisory groups." This committee will function in place of all mental retardation advisory groups that are now constituted by the various public agencies. This committee will function under the guidance of a rotating chairmanship. The committee itself will designate the function and term of office of the chairman. The Department of Public Health will continue to provide staff and executive service to the committee. It must be stressed that these duties of the Department of Public Health will be supportive and administrative and not directive.

The advantages of establisning a group such as this are considerable. It will enhance communication between the agencies, it will lead to an increase in cooperative effort in supporting and developing projects, it will help to avoid much of the duplication of effort that currently exists, it will help to launch a broad attack on the problem of mental retardation, it will alleviate the need for the establishment of the innumerable advisory groups that all agencies must deal with, it will serve as the agent of coordination, helping to bring about changes of direction and emphasis of efforts on the part of individual agencies, it will provide a forum for the airing of ideas and criticism and serve in many instances as a catalyst. It will in no way substitute for the individual agency and the agency will therefore maintain its own identity.

The Department of Public Welfare, the Department of Vocational Rehabilitation, the Department of Recreation, the Department of Public Health, the Department of Corrections, the Public School System, the United States Employment Service, and the Health and Welfare Council will be asked to nominate one person to represent their agency on this committee. The specific mode of operation of the committee will of course be determined by the committee itself. However, it is assumed that the committee will, from time to time, wish to bring into being ad hoc groups to study certain problems as well as establish subcommittees. However, it is recommended that there be no preordination of standing subcommittees lest the subcommittees be proliferated beyond reasonable bounds. Recommendations, surveys, advice, etc., should come to the committee via the individual agency structure. For example: advice in the area of education should come through the schools, counsel in the area of vocational training would be forthcoming from the Department of Vocational Rehabilitation rather than establishing subcommittees to study the subject.

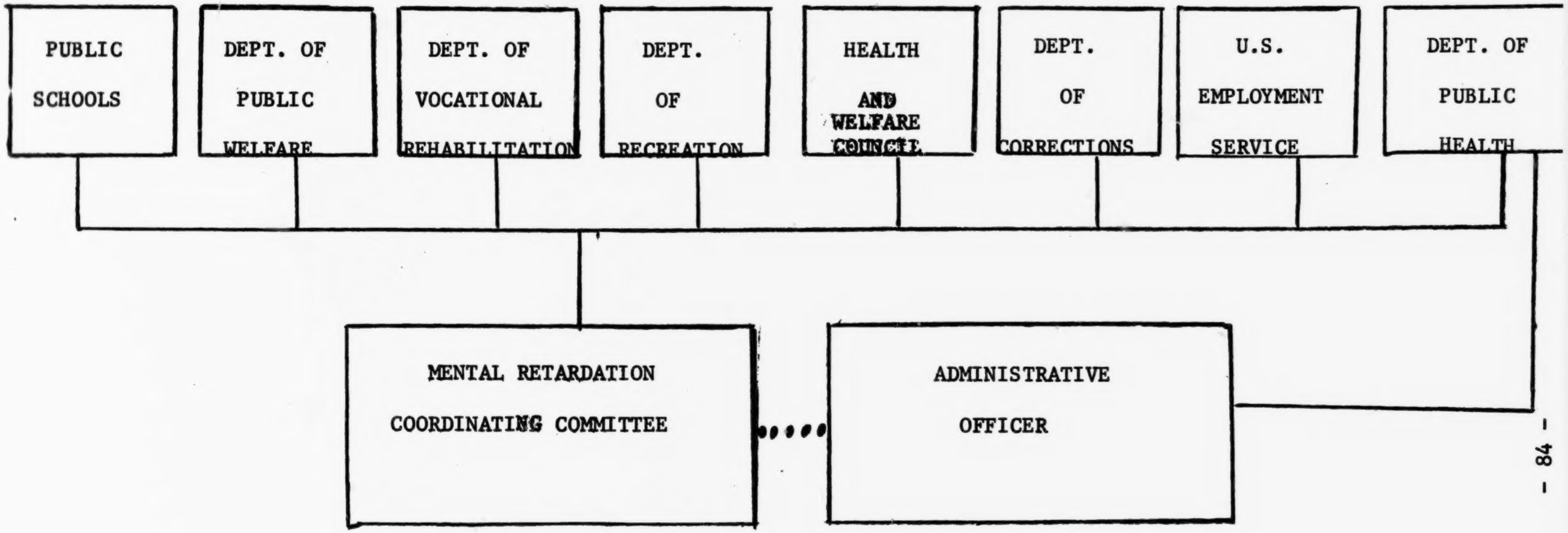
The committee will not be responsible to any one agency or to any branch of the District of Columbia Government, but it will be a force as powerful and as meaningful as the commitment each agency makes to the committee. It is in this regard that the concept of the agency itself functioning as a subcommittee to the committee is again stressed. For example: Bringing the resources of the Department of Vocational Rehabilitation to bear upon a problem coming before the committee in the area of Vocational Rehabilitation has innumerable advantages over establishing ad hoc groups to study the matter. In this way, it will be possible to focus the operational as well as the planning bodies into one action group, this has not always been possible.

A systematic delineation of areas of involvement and methods of operation for this committee are at this time impossible as well as inadvisable. The committee has the monumental task of translating into operational terms the encompassing work and recommendations of the Mental

Retardation Committee. It would seem to be most appropriate to provide this coordinating committee with the goals to be reached and allow them the discretion of finding the most suitable path to this end.

It is anticipated that this committee will begin functioning during the very early part of 1969. A meaningful plan to actualize the recommendations of the Mental Retardation Committee should be forthcoming shortly thereafter.

A schematic diagram of organizational structure of the coordinating committee is noted on the following page.


PUBLIC SCHOOLS
DEPT. OF PUBLIC WELFARE
DEPT. OF VOCATIONAL REHABILITATION
DEPT. OF RECREATION
HEALTH AND WELFARE COUNCIL
DEPT. OF CORRECTIONS
U.S. EMPLOYMENT SERVICE
DEPT. OF PUBLIC HEALTH
MENTAL RETARDATION COORDINATING COMMITTEE
ADMINISTRATIVE OFFICER

APPENDIX I

MENTAL RETARDATION COMMITTEE

Dr. Dorothy B. Ferebee - Chairman - Consultant on Comprehensive Health Services, Howard University

Dr. Frederic Burke - Vice-Chairman - Clinical Professor of Pediatrics, Georgetown University Hospital

Mrs. Ruth E. Bandy - Agency Counseling Supervisor, Services to the Handicapped, USES

Mr. William Barr - Administrator, Cedar Knoll, Children's Center - Chairman, Retarded Offender Working Party

Dr. E. Paul Benoit - Director, Comprehensive Rehabilitation Planning Project for D.C., D.C.D.V.R., Chairman, Residential Care Working Party

Dr. Heinz Berendes - Chief, Perinatal Research Branch, NINDB, Advisor

Miss Arlene Blaha - Chief, Services to the Mentally Retarded, D.V.R. - Chairman, Vocationally Related Services Working Party

Mrs. Mary Buckner - Civic Leader, Member-at-Large, former teacher

Dr. Philip Calcagno - Chairman of Department of Pediatrics, Georgetown University Hospital - Chairman of Task Force on Personnel Needs

Mr. William Carr - Chief of Psychological Service Center, Men's Reformatory, Lorton, Virginia

Dr. Robert J. Clayton - Assistant Professor of Pediatrics, Georgetown University Medical Center - Chairman on Medical and Dental Personnel Needs

Miss Edna P. Collins - Chief, Protective Services Section, Child Welfare Division DPW - Chairman, Family and Home Services Working Party

Mrs. Camille Cook - Mental Retardation Consultant, Nursing Services, Division of Health Services, Children's Bureau, HEW (nee Miss Camille Legeay)

Mrs. Henry A. Cornish - Member-at-Large, former teacher

Fr. Angelo D'Agostino - S.J., M.D., Georgetown University - Chairman, Religious Resources Committee

Mr. Samuel Dash - Executive Director, Judicial Conference of D.C. Circuit, Committee on Laws Pertaining to Mental Disorders

Dr. Edmonia W. Davidson - Associate Professor of Education, Howard University Co-Chairman, Education Working Party

Mrs. Helen Deason - Director of Preschools and Camp Activities, Department of Recreation - Chairman, Recreation and Group Activities Working Party

Mental Retardation Committee

Dr. Felix de la Cruz, Chief, Diagnostic and Study Unit, Mental Retardation Program, NICHHD: Bethesda Naval Hospital

Charles DeRoche, Esq., Help for Exceptional Little People

Dr. Roselyn Epps, Chief, Infant and Preschool Division, Bureau of MCH, DCDPH

Father John Falcone, Archdioces of Washington

Dr. Gerald M. Fenichel, Associate Neurologist, Children's Hospital - Chairman, Identification and Diagnosis Working Party

Mrs. Elyce Z. Ferster, Co-Director, The Mentally Retarded and the Law Study, George Washington University - Chairman, Task Force on Law

Dr. Maurice H. Fouracre, Director, St. John's Child Development Center

Dr. Max Frankel, Director of Special Education, The Catholic University of America

Dr. Erwin Friedman, Director, Jewish Foundation for Retarded Children

Miss Dorothy C. Grant, Pediatric Nursing Consultant, Bureau of Nursing, DCDPH

Mrs. Ruth G. Hayes, Welfare Program Coordinator, Area C Mental Health Center, Department of Public Welfare

Dr. Milton Isaacson, Chief, Division of Clinic Services, Bureau of Dental Health DCDPH

Dr. Stanley E. Jackson, Director of Special Education, D.C. Public Schools, Co-Chairman Education Working Party

Mr. John Jamison, Assistant Director, Gales Clinic for Retarded Children, DCDPH Chairman, Committee on Preparation of Social Workers

Mr. Clyde Larmer, Parent, Civitan--Chairman, Service Council

Mr. Carl Ligons, Assistant Supervisor of Education, Lorton Youth Center, Chairman, Transportation Committee

Dr. Lyle L. Lloyd, Chairman, Department of Audiology, Hearings and Speech Center, Gallaudet College - Chairman, Speech and Hearing Working Party

Mrs. Josephine M. Lopez, CHAP Officer, Bolling AFB, Needs of Service Men and Families, Chairman

Dr. Reginald Lourie, Director of Psychiatry, Hillcrest Children's Center, Advisor

Mental Retardation Committee

Dr. Allen E. Marans - Research Associate - Department of Psychiatry - Children's Hospital - Chairman - Cultural and Psychogenic Aspects of the Prevention of Mental Retardation Working Party

Capt. David J. McDonnell - USA - Social Work Officer - MDW - ACS - Ft. Myer

Dr. J. William Oberman - Medical Director - Comprehensive Health Program - Children's Hospital - Chairman - Working Party on Biological Aspects of Prevention

Dr. Richmond S. Paine - Chief of Neurology Service - Children's Hospital

Mrs. Mitzi Parks - Child Development Specialist - Child Development Center - Howard University - Chairman - Day Care Working Party

Dr. John Paul - Director - Children's Diagnostic and Development Center - Georgetown University Hospital

Dr. Helen Peixotto - Chief Psychologist - Child Center - Catholic University of America - Chairman - Committee on Personnel Needs of Psychologists

Mrs. Alice Popkin - Research Attorney - Judicial Conference of D.C. Circuit - Committee on Laws Pertaining to Mental Disorders

Mr. Guy Puntch - Institutional Administrator - District Training School - Chairman - Away From Home Care Working Party

Mrs. Dorothy E. Reese - Chief - Construction Grants Program Division of Nursing U.S. Public Health Services - Former Chairman of Mental Retardation Committee

Dr. Pearl Rosser - Director - Child Development Center - Department of Pediatrics - Howard University

Mrs. Marguerite C. Selden - Assistant to the Assistant Superintendent in charge of Urban Service Corps - Twining School

Mr. David Silberman - Executive Director - Help for Retarded Children, Inc.

Dr. Betty Simms - Associate Professor - Special Education Department - University of Maryland - Chairman of Committee on Teacher Preparation

Dr. Ronald M. Starr - Dentist - Chairman - Dental Care Working Party

Mr. Robert E. Stearns - Editor - Publication Section - Latin American Branch - USIA, Chairman - Public Information Committee

Mrs. Bertha Tayman - Principal - Tyler Elementary School - D.C. Public Schools

Miss Winifred G. Thompson - Director - D.C. Department of Public Welfare

Miss Dorothy Vaill - Director of Speech Center - D.C. Schools - Advisor

Dr. Charles L. Warren - Executive Director - Council of Churches of Greater Washington

Dr. John Washington - D.C. Medical Society - Pediatrician - Chairman - Medical Care Working Party

APPENDIX II. Task Forces and Working Parties

AWAY FROM HOME CARE

Members of Working Party on Away From Home Care

Mr. Guy Puntch - Institutional Administrator - District Training School, Chrmn.

Mr. John J. Cairns - Deputy Administrator - D.C. Village

Mrs. Elise D. Hope - Director - Half Way House - DVR

Mrs. Rose Lightman - Supervisor of Aging Program - Jewish Social Service

Mrs. Julia Riley - Foster Home Supervisor - Catholic Charities of Archidiocese of Washington

Mrs. Alice R. Smith, Chief, Child Welfare Division, DCDPW

Miss Emma Dene Winston, Urban League of the Neighborhood Development Project Family and Child Services

BIOLOGICAL ASPECTS OF PREVENTION

PERINATAL CARE

Dr. Ernest Lowe - Co-Chairman, Chief of Obstetrics and Gynecology, D.C. General Hospital, DCDPH

Dr. Artemis P. Simopoulos - Co-Chairman, Assistant Professor of Pediatrics and Director of Nurseries, George Washington University Hospital

Dr. Paul D. Bruns - Professor and Chairman of Department of Obstetrics and Gynecology, Georgetown University Hospital

Dr. Felix de la Cruz - Chief, Diagnostic and Study Unit, Bethesda Naval Hospital, NICHHD

Dr. Joseph S. Drage - Assistant Head, Pediatrics-Neurology, Section PRB, NINDB

Dr. Eileen Hasselmeyer - Special Assistant for Prematurity, NICHHD

Dr. Stafford Hawken - Chief of Gynecological Service, Columbia Hospital for Women

Dr. Andre Hellegers - Professor of Obstetrics and Gynecology, Georgetown University Hospital

Dr. J. William Oberman - Medical Director, Children's Hospital Comprehensive Health Care Program

Mrs. Patricia F. Roseleigh - Nutrition Coordinator, DCDPH

Dr. Arch Russell - Washington Hospital Center

Dr. S. Hazen Shea - Former Chairman

Dr. John Washington, D.C. Medical Society, Pediatrician, Chairman, Medical Care Working Party

PREGNANCY AND INTERCONCEPTIONAL CARE

Dr. Theodore D. Tjossem - Co-Chairman, Director, Mental Retardation Program NICHHD

Dr. Edward Wernitznig - Co-Chairman, Director of Maternity and Infant Care Project for D. C., DCDPH

Dr. Mihaly Bartolos - Chief of Medical Genetics Unit, Howard University

Dr. John Clark - Professor and Chief of Obstetrics, Howard University

Mr. Bryson S. Couvillon - Executive Director of Family Life Association of Metropolitan Washington, Community Resources Specialist, Commissioners Youth Council

Mrs. Lois Earl - Chief, Nutritional Services Division, DCDPH

Dr. Barbara Groben - Chief, Maternal Health Division, DCDPH

Dr. John Marshall - Senior Investigator, National Cancer Institute, NIH

Dr. J. William Oberman - Medical Director, Children's Hospital Comprehensive Health Care Program

Dr. Max Scherer - Endocrinologist

Dr. Winslow T. Tompkins - Consultant, Obstetrician and Gynecologist, Children's Bureau, HEW

INFANCY AND CHILDHOOD

Prevention of Mental Retardation During the Infancy and Childhood Committee Members:*

Dr. Mary Alice Fox - Co-Chairman, Pediatrician, Children's Hospital

Dr. Margaret F. Gutelius - Co-Chairman, Children's Hospital, Pediatrician

Dr. Allan B. Coleman - Pediatrician

Dr. J. William Oberman - Medical Director, Children's Hospital's Comprehensive Health Care Program

NOTE:

*Various members of D.C. Health Department provided significant consultation in the preparation of the Report.

MEMBERSHIP OF WORKING PARTY ON THE CULTURAL AND PSYCHOGENIC ASPECTS OF THE PREVENTION OF MENTAL RETARDATION

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Irene Hypps, Ph.D., Educational Specialist, United Planning Organization

Hylan G. Lewis, Ph.D., Sociologist, Director of Center of Community Studies, Graduate School, Howard University

Ruth McKay, Ph.D., Cultural Anthropologist, Department of Psychiatry, Children's Hospital

Dale Meers, Child Analyst, Department of Psychiatry, Children's Hospital

Hilary Millar, M.D., Pediatrician, Chief, Infant and Preschool Division, Bureau of Maternal and Child Health, D.C. Department of Public Health

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Reginald C. Orem, M.Ed., Associate Planning Research Corporation

John D. Schultz, M.D., Psychiatrist, Associate Director for Mental Health and Retardation, D.C. Department of Public Health

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Alice R. Smith, M.S.W., Social Worker, Chief, Child Welfare Division, D.C. Department of Public Welfare

Fred Solomon, M.D., Child Psychiatrist, Center for Youth and Community Studies, Howard University

Robert B. Sullivan, M.D., Child Psychiatrist, Psychiatric Consultant, Children's Convalescent Hospital

Thomas Taylor, M.S.W., Executive Director, National Capital Area Child Day Care Association, Inc.

Winifred G. Thompson, M.S.W., Director, D.C. Department of Public Welfare

Bathrus Williams, M.S.W., Special Education Teacher, D.C. Public Schools

DAY CARE

DAY CARE WORKING PARTY MEMBERS:

Mrs. Mitzi Parks, Child Development Specialist, Child Development Center, Howard University, Chairman

Mrs. Rena Becker, Child Development Specialist, Gales Clinic for Retarded Children DCDPH

Mrs. Mary Jane Edlund, Child Day Care Association - Montogmery County

Mrs. Adelia Heiney, Administrative Officer, Bureau of Maternal and Child Health DCDPH

Mrs. Margaret B. Harris, Social Worker, Child Day Care Association

Miss Joan Hunt, Psychologist, Institute for Child Study, University of Maryland

Mrs. Jenny Klein, Program Director for Montgomery County ARC, (former)

Mrs. Adeline Mazur, Social Worker, Jewish Foundation for Retarded Children

Mrs. Laura McLaughlin, Education Specialist, Child Research Branch, NIH

Miss Rosalie Melton, Child Care Standards Worker, Bureau of MCH, DCDPH

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Miss Sharon Smith, Director, Activity Center Program Arlington

Mrs. Elaine Starbuck, Director, Prince George's County Retarded Day Care Center

Mrs. Mary Waldrop, Director of Nursery School, Child Research Branch, NIMH

DENTAL CARE

MEMBERS OF DENTAL CARE WORKING PARTY:

Dr. Ronald Starr - Dentist, Consultant to Jewish Foundation for Retarded Children Chairman

Dr. Charles Broring - Assistant Professor, Department of Pedodontics Georgetown University

Dr. Morton Goode - Chairman of D.C. Dental Society Committee on Mental Retardation

Dr. Milton Isaacson - Chief, Division of Clinic Services, Bureau of Dental Health DCDPH

Dr. James L. McCarron - Chairman, Committee on Dentistry for Handicapped at Holy Cross Hospital

Dr. John Palmer - Chief Dental Officer, Children's Center-Laurel, Maryland

Dr. William Vlahov - Dentist, Group Health Association, Parent

EDUCATION

EDUCATION WORKING PARTY MEMBERS

Dr. Edmonia W. Davidson, Associate Professor of Education, Howard University Co-Chairman
Dr. Stanley Jackson, Director of Special Education, D. C. Public Schools, Co-Chairman

Dr. I. Blanche Bourne, Coordinator, School Health Program, DCDPH

Mrs. Wilma Daniels, Teacher, D. C. Public Schools

Mrs. Rosa DeSouza, Supervisor for Educational Classes, Phillips Annex, D.C. Schools

Fr. John Falcone, Office of Education, Archdiocese of Washington

Dr. Maurice Fouracre, Director, St. John's Child Development Center

Mrs. Gloria E. Frankel, Principal, Jewish Foundation for Retarded Children

Mrs. Elizabeth Goodman, Education Specialist, Office of Disadvantages and Handicapped U.S. Office of Education

Mrs. Dorothy Hamilton, Principal, Junior Village School, DCDPW

EDUCATION WORKING PARTY MEMBERS - CONTINUED

Mrs. Elaine Hollander, Former Teacher, Doctoral Student, American University

Mr. William Jefferson, Teacher, Paul Jr., H.S., D.C. Schools

Mrs. Marjorie Johnson, Supervisor, Phillips Annex, D.C. Public Schools

Dr. Gertrude Justison, Associate Professor, Department of Education, Howard University

Mrs. Jenny Klein, Program Director, Montgomery County, ARC

Dr. Theodore Libber, Supervising Director of Curriculum, Phillips Annex, D. C. Public Schools

Sister Monica Marie, Principal, St. Maurice Day School

Sister Maureen - Director, St. Gertrude's School of Arts and Crafts

Dr. Margaret Mercer, Director, Program for Personality Assessment Behavioral Branch, Saint Elizabeth's Hospital

Mrs. Eva Nash, Social Worker, Developmental Services Center, DCDPH

Mrs. Ethel Neustadter, Principal, Sharpe Health School

Mrs. Anne W. Pitts, Supervising Director, Model School Division, D.C. Public Schools

Mrs. Jean Pratt, Teacher, Eastern High School

Mrs. Elinor Ring, Director, Pilot School for Blind Children

Sister Mary St. Anne, Director, Kennedy Institute

Mrs. Louise Steel, Former Member, D. C. School Board

Miss Barbara Stockton, School Psychologist, Department of Pupil Personnel Services, D. C. Public Schools

Mrs. Bertha Tayman, Principal, Tyler School, D. C. Schools

Mrs. Rita Valeo, Director, Army Rejectee Rehabilitation Project

Mr. Robert Volland, Director, Vocational Education, D. C. Public Schools

Mrs. Bathrus Williams, Teacher

Mrs. Marian O. Williams, President, C.E.C. Chapter 49

Mr. Jimmy Wyatt, Acting Superintendent of Schools, Children's Center

FAMILY AND HOME SERVICE

MEMBERS OF WORKING PARTY ON FAMILY AND HOME SERVICES:

Miss Edna P. Collins - Chief, Protective Services Section, Child Welfare Division
Chairman, DPW

Mrs. Polly Adams - Board Members, Homemaker Service of National Capital Area

Mrs. Helen Curley - Director of Nursing Service, Children's Center, DPW

Mrs. Lois Earl - Chief, Nutritional Services Division, DCDPH

Miss Patricia Gilroy - Executive Director, Homemaker Service of the National Capital Area

Mrs. Viola J. Lee - Assistant Chief, Public Assistance Division, DPW

Mrs. Aretta Moore - Acting Director, Help for Retarded Children

Mr. William H. Thomas - Lawyer, formerly with Social Security Administration Washington District Office

IDENTIFICATION AND DIAGNOSIS

MEMBERS OF WORKING PARTY:

Dr. Gerald Fenichel - Associate Neurologist, Children's Hospital, D.C. Chairman

Dr. Roselyn Epps, Chief, Infant and Preschool Division, Bureau of MCH, DCDPH

Dr. David St. Martin, Director, Child Center, Catholic University of America

Dr. Leon Cytryn, Research Associate, Children's Hospital and Consultant, Jewish Foundation for Retarded Children

COMMITTEE ON IDENTIFICATION AND DIAGNOSIS OF SCHOOL AGED RETARDED CHILD

The Mental Retardation Committee decided, after reviewing The Progress Report, that a study of this area in depth was necessary. The following served on this committee:

Dr. Gerald M. Renichel	Chairman, Associate Neurologist Children's Hospital
Mr. Fred Aranha	Principal, Roper Junior High School
Sister Cecilia	Teacher, Kennedy Institute
Mrs. Vera Davenport	Counselor, Stanton Elementary School
Mrs. Johnetta Davis	Speech Correctionist for D.C. Schools
Dr. Roselyn Epps	Director, Gales Clinic for Retarded Children, D.C. Department of Public Health
Miss Geraldine A. Graham	Clinical Psychologist, Department of Pediatrics, Howard University
Mrs. Dorothy Hamilton	Principal, Junior Village School
Dr. Gertrude Justison	Associate Professor, Department of Education, Howard University
Dr. Mark Ozer	Associate Neurologist, Children's Hospital
Mrs. Rose L. Paper	Classroom Teacher, President Washington Chapter, C.E.C.
Mrs. Lois Pilch	Mental Retardation Nursing Consultant, Bureau of Nursing, DCDPH
Dr. Rebecca Rieger	Psychologist, Children's Hospital
Mrs. Elinor B. Ring	Director, Pilot School for Blind Children, Inc
Dr. Pearl Rosser	Director, Child Development and Diagnostic Center, Dept. of Pediatrics, Howard University
Mrs. Theresa St. Hilaire	Chief Psychologist, D. C. Society for Crippled Children
Mrs. Marilyn Schoming	Educational Counselor, Department of Special Education, Prince Georges County School

COMMITTEE ON IDENTIFICATION AND DIAGNOSIS OF SCHOOL AGED RETARDED CHILD - Con'td.

Dr. Betty Simms	Assistant Professor of Education, Special Education Department, University of Maryland
Mrs. Claire Simpson	Mott Center, Pupil Personnel Center
Mrs. Louise S. Steele	School Board Member
Mrs. Ruth Strauss	Supervising Director of Special Education, Junior and Senior High Schools
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MEDICAL CARE

MEMBERS OF THE MEDICAL CARE WORKING PARTY ARE:

Dr. John A. Washington - Pediatrician, Rep., D.C. Medical Society - Chairman

Dr. James Boyland - Medical Officer - District Training School, Laurel, Maryland

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Dr. Thomas Reichelderfer - Chief Pediatrics Department, D.C. General Hospital

Dr. Stanley I. Wolf - Medical Director, Jewish Foundation for Retarded Children

NURSING SERVICES

NURSING SERVICES COMMITTEE MEMBERS ARE:

Miss Mary Helen Carroll - Nursing Coordinator for MIC Project, Bureau of Nursing DCDPH

Miss Pat Catanzaro - Chief Nurse, Comprehensive Health Care, Children's Hospital

Mrs. Camille Cook - Mental Retardation Consultant, Nursing Services, Division of Health Services, Children's Bureau, HEW-Advisor (nee Miss Camille Legeay)

Mrs. Louise K. Cornetta - Director of Nursing, Jewish Foundation for Retarded Children

NURSING SERVICES COMMITTEE MEMBERS, CONTINUED

Mrs. Grace Crifasi - Nurse, Kennedy Institute and Parent

Mrs. Helen Curley - Director of Nurses - Children's Center, Laurel, Maryland

Mrs. Bette Faries - Assistant Professor of Nursing Education, School of Nursing Montgomery Junior College

Mrs. Olivette Gill - Mental Health Nursing Consultant, Bureau of Nursing, DCDPH

Mrs. Nancy Goodrich - Chairman, Nursing Department - Marymount Jr. College

Miss. Dorothy C. Grant - Pediatric Nursing Consultant, Bureau of Nursing, DCDPH - Chairman

Mrs. Mary Grisez - Supervisor of Health Unit, Child Welfare Division, DPW

Miss Doris Haar - Nursing Consultant, Division of Mental Retardation - Rehabilitation Services Administration, Social and Rehabilitation Service, HEW, Advisor

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Mrs. Betty Ivey - Head Nurse, Junior Village Infirmary, DPW

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Mrs. Shirley Scales - Public Health Nursing Consultant, Child Development Center Howard University

Mrs. Cecilia Shaw, Instructor, Maternal and Child Nursing Program, School of Nursing Georgetown University

Mrs. Evelyn Tennant - Head Nurse, Pediatric Department, Georgetown University Hospital

PREPARATION OF TEACHERS

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Dr. Max Frankel, Director of Special Education, The Catholic University of America

Dr. Edith Grotberg Associate Professor of Education, American University

Dr. Jean Hebeler, Coordinator of Special Education, University of Maryland

Dr. Gertrude Justison, Associate Professor, Department of Education, Howard University

Mr. Peter Swindler, Director of Special Education, D.C. Teachers College

Mrs. Marian Williams - President, Washington, C.E.C. Chapter

PUBLIC INFORMATION

MEMBERS OF COMMITTEE:

Mr. Robert E. Stearns, Editor Publication Section, Latin American Branch, USIA

Mr. Warren Abrams, Washington Post

Mr. Richard K. A'Hearn, Production Manager, WRC-TV, NBC

Mr. Clarence Enzler, Toastmasters International, District 36

Mr. Gershon Fishbein, Editor, Environmental Health Letter

Mr. John Irvin, Public Health Advisor, D.C. Department of Public Health

Mr. Thomas W. Ledbetter, Immunization Specialist, D.C. Department of Public Health

Mr. Wil Lepkowski, American Chemical Society

Mr. James F. McCollum, Printing Industry

Mrs. Catherine Meyer, Religious Educator, Trinity Lutheran Church

Mr. Charles Mooshian, Public Information Specialist, Health Education and Information Division, D.C. Department of Public Health

Mrs. Mitzi Parks, Child Development Specialist, Child Development Center, Howard University

Mr. Clyde H. Reid, Public Information Officer, D.C. Department of Public Welfare

Mr. Richard C. Thompson, Staff Consultant, President's Committee on Mental Retardation

Preparation of Psychologists

Members of Committee on Preparation of Psychologists:

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Mrs. Pauline Dines, Psychologist, Handicapped Crippled Children's Clinic D.C. General Hospital
Dr. Erwin Friedman, Director, Jewish Foundation for Retarded Children
Dr. Bernard Levy, Professor of Psychology, George Washington University
Dr. Adam P. Matheny, Psychologist, Children's Diagnostic & Study Unit (Navy 125), NICHD, National Institute of Health
Dr. Malcolm Meltzer, Chief Psychologist, D.C. General Hospital
Dr. Margaret Mercer, Director, Program for Personality Assessment, Behavioral Studies Branch, St. Elizabeth's Hospital
Mr. Wilbur A. Millard, Assistant to the Asst. Superintendent, Dept. of Pupil Personnel Services, D.C. Schools
Dr. William R. Perl - Chief, Psychology Department, D.C. Children's Center, Laurel
Dr. Mary E. Reidy, Clinical Psychologist, Georgetown University Hospital
Miss Sara Saltzman, Chief Psychologist, Hillcrest Children's Center Children's Hospital
Dr. Robert S. Waldrop, Professor of Psychology, University of Maryland

Preparation of Social Workers

Members of Committee on Preparation of Social Workers
Mr. John Jamison - Ass't. Dir., Gales Clinic for Retarded Children, DCDPH, Chairman
Mrs. Ruth Adams - Professor, School of Social Work, Howard University
Miss Joyce Balansky - School of Social Work, Howard University
Dr. Michael J. Begab - Social Science Advisor, Mental Retardation Program, NICHD
Mrs. Margery P. Carpenter - Member at Large
Mrs. Ruth O. Currie - Chief Social Worker, Jewish Foundation for Retarded Children
Mrs. Pat Gausden - Chief Social Worker, Children's Hospital
Mrs. Ruth G. Hayes - Welfare Program Coordinator, Area C Community M.H. Center, DPW
Mrs. Edith Kalech - Formerly of Georgetown University and District Training School
Mrs. Laura Lunn - Social Worker, Children's Diag. & Dev. Center, Georgetown U. Hospital
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Mrs. Eva L. Nash - Supervisory Social Worker, DCDPH, Dev. Services Center
Mr. Gene Sullivan - Assistant Professor, School of Social Service, Catholic University
Mr. James T. Wallace - Social Work Supervisor, Child Development Center, Howard U.
Mrs. Jane Wickey - Chief, Social Service, Children's Center, Laurel
Mrs. Marjorie H. Kirkland - Former member - formerly with Children's Bureau, now Mental Retardation Consultant, Dallas, Texas Regional Office

Needs of Service Personnel & Their Families

Members of the Committee

Mrs. Josephine Lopez, CHAP Officer, Bolling AFB, D.C.; Chairman
Mrs. Alice Abramson, Education Specialist, Diagnostic & Study Unit, NICHHD, National Naval Medical Center, Bethesda, Md.
Captain Florence E. Anderson, Coordinator, Army Community Services, Fort Belvoir, Va.
Mrs. Otti Brecker, Intake Worker, Outpatient Clinic, U.S. Public Health Service, Washington, D.C.
Lt. Col. Donald S. Carter, Army Community Services, Walter Reed Army Medical Center
Mrs. Philip C. Conway, Volunteer, Army Comunity Services, Fort Belvoir, Va.
Mrs. Eleanor M. Costello, Volunteer, Army Community Services, Walter Reed Army Medical Center
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Mrs. Viola Cunningham, Chief Social Worker, U.S. Public Health Service, Washington, D.C.
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Mrs. Lois S. Ford, Navy Family Services, Anacostia Naval Station, D.C.
Mrs. Sheila B. Gefen, Social Worker, Project CHAP, Andrews AFB
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LCDR Fred H. Gramling - Environmental Sciences Service Administration
Mrs. Frederick Haase, Volunteer, Army Community Services, Walter Reed AMC
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Mrs. Marie Hunter, Personal Affairs Officer, Headquarters, Air Force Systems Command, Andrews AFB
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Captain David J. McDonnell, Social Worker Officer, Army Community Services, Military District of Washington, Fort Myer, Va.
Mrs. Janet Norcott, Volunteer, Army Community Services, Walter Reed AMC
Major Ruth O. Nehf, Family Assistance Officer, Personal Affairs Branch, Hqs. U.S. Marine Corps, Washington, D.C.
Mr. J.E. Parks, Deputy Director, Army Community Services, Ft. George G. Meade, Maryland
Captain Ronald J. Platte, O.S.C., Walter Reed A.M.C.
Mrs. Elizabeth W. Read - ACS, Walter Reed AMC
Mrs. Irene Smoke, Volunteer, Army Community Services, Fort Belvoir, Va.
M/Sgt. Florence E. Sullivan, Army Community Services, Fort Belvoir, Va.
Mrs. Mary E. Thompson, Volunteer, Army Community Services, Fort Belvoir, Va.
Lt. Doris R. Vail, Navy Family Services, Anacostia Naval Station, D.C.
Mrs. Mary Van Buskirk, Volunteer, Army Community Services, Walter Reed A.M.C.
CWO Harold C. Wadey, Headquarters, U.S.Coast Guard, Washington, D.C.
Mrs. Penny Ware, Volunteer, Army Community Services, Walter Reed A.M.C.
Mrs. Helen M. Wesley, Volunteer, Army Community Services, Fort Belvoir, Va.

Religious Resources

Members of Committee on Religious Resources are:

Reverend Father Angelo D'Agostino, S.J., M.D., Georgetown University, Chairman
Dr. E. Paul Benoit, Director, Comprehensive Rehabilitation Planning Project for D.C., D.C. Dept. of Vocational Rehabilitation
Sister Collette, Confraternity of Christian Doctrine, Archdiocese of Washington
Reverend Father Ramon A. di Nardo, Consultant on Religious Education, Archdiocese of Washington
Sister Mary Dolores, Religious Educator, Lt. Joseph P. Kennedy, Jr. Institute
Father John Falcone - Archdiocese of Washington
Dr. Samuel Gandy, Dean, School of Religion, Howard University
Father Rudolph Gawlik - CSC, Holy Name Rectory
Reverend Father Edwin Ginder, Catholic Chaplain, District Training School
Reverend David E. Gregory, Protestant Chaplain, District Training School
Mrs. Joseph Hagarty, Religious Educator, St. Charles Church, Arlington, Va.
Miss Dorothy Harris - Religious Educator, Vermont Avenue Baptist Church, Wash.
Dr. Fred E. Henry, Chaplain, Devereux Schools, Devon, Pa.
Dr. Julius Hoffman, Psychiatrist - Consultant, Washington, D.C.
Mr. Forest Kerstetter, Religious Educator, Falls Church, Va.
Rabbi Hillel Klavan, Ohev Sholom Talmud Torah Congregation, Washington, D.C.
Mrs. Charlotte Kraus, Special Education Department, University of Maryland
Dr. Reginald Lourie, Director of Psychiatry, Hillcrest Children's Center, Washington, D.C. - Consultant
Sister Monica Marie, Principal, St. Maurice Day School, Bethesda, Maryland
Sister Maureen, Director, St. Gertrude's School of Arts and Crafts, Washington, D.C.
Mrs. Walter McArdle, Silver Spring, Md.
Mrs. Leroy Meyer, Religious Educator, Trinity Lutheran Church, Washington, D.C.
Reverend S. Lewis Morgan, Pastor, Montgomery Hills Baptist Church, Silver Spring, Md.
Mrs. Virginia Morgan, Department Head, Pre-Vocational Program, Help for Retarded Children, Inc., Washington, D.C.
Reverend Father Joseph A. O'Brien, Catholic Chaplain, St. Elizabeth's Hospital, Washington, D.C.
Mrs. Mitzi Parks, Child Development Specialist, Child Development Center, Howard University
Dr. John Paul, Professor of Pediatrics, Children's Diagnostic and Development Center, Georgetown University
Sister Rosalie, Formerly with Confraternity of Christian Doctrine, Archdiocese of Washington
Reverend J. W. Rush, Pastor, St. Luke's Methodist Church, Falls Church, Va.
Rabbi Samuel Scolnic, Congregation Beth - El of Montgomery County, Bethesda, Md.
Reverend Lee S. Varner, Pastor, Christ Methodist Church, Arlington, Va.
Rabbi Chaim Williamowsky, Formerly Director of Jewish Activities for St. Elizabeth's Hospital, Washington, D.C.
Reverend George Williams, Associate Pastor, Asbury Methodist Church, Washington, D.C.
Mr. Ben Wostein, Religious Educator, Jewish Foundation for Retarded Children
Rev. Charles Ellett - Director of Research and Planning, Council of Churches of Greater Washington

Residential Care

Members of the Working Party of Residential Care are:

- Dr. E. Paul Benoit - Director, Comprehensive Rehabilitation Planning Project for D.C., DCDVR, Chairman
- Mrs. Bertha Atkin - Parent, Friends of Forest Haven
- Mrs. Margery P. Carpenter - Member at Large
- Dr. Erwin Friedman - Director, Jewish Foundation for Retarded Children
- Miss Geraldine A. Graham - Clinical Psychologist, Child Development Center, Howard University
- Mr. Harry Manley - Executive Director, Bureau of Rehabilitation, National Capital Area
- Sister Maureen - Director, St. Gertrude's School of Arts and Crafts
- Dr. Jack Noone - Executive Director, American Association on Mental Deficiency
- Mr. Carl Oliver - Administrator, Maple Glen
- Mr. Guy Puntch - Institutional Administrator, District Training School, Laurel
- Mrs. Miriam P. Speck - Director, Partridge Schools and Rehabilitation Center
- Miss Winifred G. Thompson - Director, Department of Public Welfare
- Mrs. Jane Wickey - Chief, Social Service, Children's Center, Laurel

Recreaction and Group Activities

Members of Working Party:

- Mrs. Helen Deason - Director of PreSchools and Camp Activities, Department of Recreation, Chairman
- Mr. William Anderson - Director of Recreation, District Training School
- Mr. Raymond Bady - Executive Director, Southwest Community House Association
- Mrs. Rena Becker - Child Development Specialist, Gales Clinic for Retarded Children, DCDPH
- Mrs. Sally Cole - Instructor, Help for Retarded Children, Inc.
- Dr. Maurice H. Fouracre - Director, St. John's Child Development Center
- Mrs. Elise O. Hope - Director, Half-Way House, Department of Vocational Rehabilitation
- Mr. Ron Johnson - Instructor, Department of Health, Physical Education and Recreation, University of Maryland
- Mrs. Dorothy MacConkey - Parent, George Mason College, Fairfax
- Sister Maureen - Director, St. Gertrude's School of Arts and Crafts
- Miss Helen Jo Mitchell - Director-Coordinator, Recreation Program for the Retarded, D.C. Recreation Department
- Mrs. Aretta Moore - Program Director, Help for Retarded Children, Inc.
- Mrs. Rose L. Paper - Teacher, Graduat Student, George Washington University
- Mrs. Elinor Ring - Director, Pilot School for Blind Children
- Sister Mary St. Anne - Director, Kennedy Institute
- Mr. Matt Travers - Parent, Georgetown Kiwanis Club

The Retarded Offender

Members of the Working Party are:

Mr. William Barr - Administrator, Cedar Knoll, Children's Center, Chairman
Mr. William Carr - Chief of Psychological Service Center, Men's Reformatory, Lorton, Virginia
Mr. Joseph Cheek - Administrator of Community Treatment Center of Youths, D.C. Department of Corrections
Thomas F. Courtless, Ph.D. - Director of Criminological Studies, Institute of Law, Psychiatry and Criminology, George Washington University
Mr. William O. Ford - Chief, Institutional Care Section, Child Welfare Division, D.C. Department of Public Welfare
Mr. Harold Huie - Probation Officer, D.C. Juvenile Court
Mr. John Miller - Psychologist, D.C. Department of Corrections, Lorton, Virginia
Mr. Fred Petersen - Deputy Chief, U.S. Probation Office, Washington

Speech and Hearing

Members of Speech and Hearing Working Party are:

Dr. Lyle L. Lloyd - Chairman, Department of Audiology, Gallaudet College Chairman
Mr. Robert Honeygosky - Assistant Professor, Speech Clinic, George Washington University, Vice-Chairman
Dr. Peter A. Campanelli - Section Chief, Clinical Audiology and Speech Pathology, Bureau of Maternal and Child Health, DCDPH
Miss Mary Ann Clark - Education Specialist, Bureau of Education for the Handicapped, Office of Education, HEW
Mr. William T. Daley - Director, Speech and Hearing Clinic, Catholic University of America
Miss Ruth A. Hudnut - Director, Washington Hearing Society
Dr. Charles G. Hurst - Head, Department of Speech and Hearing, Howard University
Mrs. Elissa Johnson - Director, Speech and Hearing Clinic, Howard University
Miss Alice Monroe - Chief, Speech Therapy Section, Department of Physical Medicine, Georgetown University Hospital
Mr. William Mullen - Assistant Director, Children's Hearing and Speech Center, Children's Hospital
Dr. Capt. Jerry Northern - Assistant Director, Audiology and Speech Center, Walter Reed General Hospital
Dr. Rex V. Naylor - Speech Pathology, U.S. Naval Hospital
Mrs. Mary D. Rastatter - Clinical Audiologist, St. Elizabeths Hospital
Mr. William Simpkins - Supervisor of Speech Pathology and Psychology, Walter Reed General Hospital
Miss Jill Stormer - Speech Therapist, St. John's Child Development Center
Miss Dorothy Vaill - Director of Speech Center, D.C. Public Schools
Miss Josephine Walker - Supervisor of Hearing Evaluation, Audiology and Speech Center, Walter Reed General Hospital

The Service Council
on
Mental Retardation in D.C.

Mr. Clyde M. Larmer, Chairman

Members of Parents' and Special Interest Groups

Officers:

- Chairman - Mrs. Catherine Milner, Lincoln-Banneker Parents Club, Help for Retarded Children, Inc. - Board Member
- Vice-Chairman - Mrs. Aretta Moore, Program Director, Help for Retarded Children, Inc.
- Secretary - Mrs. Dolly Jones - President, Friends of Forest Haven
- Delegate - Mr. Robert Bostick, Richardson School Parents
- Delegate - Unfilled at present
- Alternates -
    - Mrs. Sigmund Timberg - Member-at-Large
    - Mrs. Rosetta Mitchell - Council for Exceptional Children, Washington Chapter #49
    - Mr. Harry Wallace - Parent Coordinator, D.C. Society for Crippled Children

Members:

- Dr. Perry Botwin - President, Council on Exceptional Children, D.C. Federation #524
- Parent, CHAP - Chapel Parents' Group, Bolling AFB
- Miss Juanita Hill - Social Worker, CHAP Program, Andrews AFB
- Mrs. Rosa Jones - Chairman, Exceptional Child Committee, D.C. Congress of Parents and Teachers
- Mrs. Howard Young - Program Assistant, D.C. Mental Health Association
- Miss Alice Bowman - The Epilepsy Foundation
- Miss Sally McGuire - The Epilepsy Foundation
- Mrs. Helen Pagano - Friends of Forest Haven
- Mrs. Ophelia J. Roache - President, Parents Organization, Head Start Program
- Charles DeRoche, Esq. - Help for Exceptional Little People
- Dr. Eva Johnson - President, Help for Retarded Children, Inc.
- Mr. Robert Stein - Vice-President, Parents' Group, Jewish Foundation for Retarded Children
- Mr. George Isbell - Parents' Group at the Lt. Joseph P. Kennedy Jr, Institute
- Mr. Thomas Baldwin - President, Parents' Group, Kendall School for the Deaf
- Mrs. Marta Logan - President, Lenox Annex School Parent Club
- Mr. Charles Warfield - President, Military Road School PTA
- Mrs. William C. Baisinger - National Foundation - March of Dimes
- Mrs. Leslie Grant - President, National Society for Autistic Children
- Mr. Lawrence S. Lotzi - President, Partridge School PTA
- Mrs. Julia Hughes - Pilot School for Blind Children
- Mrs. Elsie J. Hamilton - Teacher, Richardson School
- Mr. James Earle - President, Sharpe Health School PTA
- Mr. Raymond E. Lentz, Jr. - President, Parent-Teachers League, St. Gertrude's School of Arts and Crafts
- Mrs. Rosalie Iadarola - St. John's Child Development Center Parents' Group

Members of the Youth Council on Mental Retardation in D.C.

Coordinator, Youth Service Project on Mental Retardation - Mrs. Margery Carpenter

Officers:

Chairman - Miss Carolyn McKay, Marjorie Webster Junior College
Vice-Chairman - Mr. Tom Schweller, Georgetown University
Recording Secretary - Miss Penelope Blount, Burdick Vocational High School
Corresponding Secretary - Miss Carolyn Gilliam, M.M. Washington Vocational High School
Historian - Miss Barbara Palen, Georgetown University
Delegates:

Miss Priscilla Abbitt - Burdick Vocational High School
Mr. Marvin L. Tuten, Jr. - Spingarn High School

Alternates:

Mr. Richard A. Lawson - American University
Mr. Nathaniel Hamlett - Phelps Vocational High School
Mrs. Venus Bell - M.M. Washington Vocational High School
Mr. Curtis Baylor - McKinley High School
Miss Lynn Shapiro - Woodrow Wilson High School
Mr. Julius Thompson - Bell Vocational High School
Mr. Phillip Ayers - Anacostia High School

Members According to School, College or University

D.C. Public High Schools

Anacostia - Mr. William Richmond
Mr. Phillip D. Ayers

Ballou - Mr. Fred Lucas

Bell Vocational - Mr. Julius R. Thompson

Burdick Vocational - Miss Priscilla Abbitt
Miss Penelope Blount

Cardozo - Miss Alice Green

Chamberlain Vocational - Miss Gloria J. Witherspoon

Dunbar - Miss Jacqueline Worthy

Eastern - Mr. Terence O. Billingsley
Miss Rachel Connley
Mr. Ricardo Lewis
Mr. Mario Schowers

McKinley - Mr. Curtis A. Baylor

Phelps Vocational - Mr. Nathaniel Hamlett, Jr.

Roosevelt - Miss Josephine Dukes

Spingarn - Mr. Marvin L. Tuten, Jr.

Washington Vocational-Mrs. Venus Bell
Miss Ellen Diggs
Miss Carolyn Gilliam
Mrs. Elizabeth Johnson

Western - Mr. Walter Combs

Woodrow Wilson - Mr. Mike Klein
Miss Lynn Shapiro

Parochial High Schools

Holy Trinity - Miss Joan Bienvenue
Miss Katie Walsh

Private Catholic High Schools and Colleges

Dunbarton College of Holy Cross - Miss Ann Gregory

Gonzaga High School - Mr. Bob Ronayne

Trinity College - Miss Gay Jacobs
Miss Terry Jacober

Colleges and Universities

American University - Mr. Richard A. Lawson

Catholic University of America - Miss Evelyn Joray
Mr. John Kirian

D.C. Teachers College - Miss Barbara Carter

Georgetown University - Miss Bonnie Ameche
Miss Barbara Palen

George Washington University - Mr. Dave Fishback
Miss Nancy Meyer

Howard University - Mr. Douglas Garland

Marjorie Webster Junior College - Miss Cathy Crowl
Miss Carolyn McKay

Other Representation

Protestant Youth of the Chapel, Bolling AFB - Miss Kathy Heffron
Miss Byrde Pettigrew

Urban Service Corps (D.C. Public Schools) - Miss Beatrix Davis

Advisory Board of the Youth Council on Mental Retardation

Mr. Stanley Anderson - Children's Bureau, U.S. Department of HEW
Mr. William G. Anderson - Director of Recreation, District Training School
Mrs. Rena Becker - Child Development Specialist, D.C. Clinic for Retarded Children
Mrs. G. Y. Brown - Faculty Sponsor for Student Council, M.M. Washington Vocational High School
Mr. Joseph Cheek - Administrator of Community Treatment Center for Youths
Miss Elayne Cousin - D.C. Commissioner's Youth Council
Mrs. Helen Deason - Director of Pre-Schools and Camp Activities, D.C. Department of Recreation
Mrs. Hilda Fishback - D.C. Department of Vocational Rehabilitation
Mrs. Ruth Hayes - Welfare Program Coordinator, Area C Community MHC
Dr. Stanley E. Jackson - Director of Special Education, D.C. Public Schools
Mrs. Chrystine C. Jaffe - Supervisor of Volunteers, Jewish Foundation for Retarded Children
Dr. Eva Johnson - President, Help for Retarded Children, Inc.
Mrs. R. S. McLellan - Director of College and Junior Red Cross, D.C. Chapter, American National Red Cross
Mrs. Catherine Milner - Chairman, Service Council Section on Parents' and Special Interest Groups, Board Member, Help for Retarded Children, Inc.
Miss Helen Jo Mitchell - Director-Coordinator, Recreation Programs for Retarded Children, D.C. Recreation Department
Mrs. Mitzi Parks - Child Development Specialist, Child Development Center, Howard University
Miss Lynne D. Perkins - Lt. Joseph P. Kennedy, Jr. Foundation
Dr. Catharine Richards - Children's Bureau, U.S. Department of Health, Education and Welfare
Mr. Charles Rogers - Chairman, Boys and Girls Committee for the National Capital District - Kiwanis International
Reverend Father Raymond E. Runde - President, Student Chapter, Council on Exceptional Children
Mrs. Katherine Sockwell - Advisor of the Student Council, Burdick Vocational High School
Mr. David L. Terrell - Baker's Dozen Youth Center
Mr. Leon W. Weaver - Teacher, Phelps Vocational High School
Sgt. James S. Wetzel - Sponsor, Protestant Youth of the Chapel, Bolling AFB
Miss Nancy Wright - Instructor, Help for Retarded Children, Inc.

Members of Service and Fraternal Organizations

Officers:

Chairman - Mr. Maurice A. Davis, Mecca Temple No. 10, A.E.O.N.M.S.
Vice-Chairman - Mr. Ronald M. Beard, Downtown Jaycees
Secretary - Mr. Dorothy Sacks, Ki-Wives Northeast Kiwanis Club
Delegates - Mrs. Carrie Gant, Georgianna Thomas Grand Chapter, OES
Mr. Freddie King, Prince Hall Grand Lodge of Masons
Alternates - 3 - Unfilled at present time

Members:

- Mr. Milton Byrne, Civitan Club of Washington, D.C.
- Mr. J. Dale Gilliland, Immediate Past State President of Jaycees in D.C.
- Mrs. Henry Griggs, Junior League of Washington
- Mr. Thomas J. Stohlman, Georgetown Kiwanis Club
- Mr. Charles Rogers, Chairman, Boys and Girls Committee for National Capital District - Kiwanis International
- Mr. Carl Romborg, Chairman, Vocational Guidance Committee, Downtown Kiwanis Club
- Mr. Austin P. Gattis, Immediate Past President, Washington Host Lions Club
- Mr. Bo Wright, Northwest Optimist Club
- Mr. Clarence Enzler, Toastmasters International - District 36
- Mr. George Douglas, Washington Round Table
- Mrs. Rosalie Kennedy, Zeta Phi Beta Sorority, Inc.
- Mr. Harry Fauber, Northeast Kiwanis Club
- Mr. Dave Schrader, Assistant National Chairman for Jaycees' Mental Retardation Projects
- Mr. Andrew J. Kress, Knights of Columbus, Washington Council 224
- Mrs. Helen Wilson, Grand Chapter of Eastern Star in D.C.

Members of Citizens' Organizations (Broad Membership Groups)

- Mrs. Doris Covington, University Neighborhood Council
- Mrs. M. Gertrude Elliott, Department Senior Vice-President - Ladies Auxiliary to the V.F.W., Department of D.C.
- Mrs. Jeanette F. Udo, Department President, Ladies Auxiliary to the V.F.W., Department of D.C.
- Mr. Edward A. Langley, American Legion, Department of D.C.
- Mr. Charles Laser, Jr., D.C. Republican Committee
- Mr. William Jordan, National Council of Senior Citizens, Washington Chapter
- Mr. Samuel Morch, D.C. Health and Welfare Council
- Mrs. Eleanor F. Turner, D.C. Department of Public Welfare, Child Welfare Division
- Mrs. Louise Malone, D.C. Citizens for Better Public Education
- Mrs. Lillian Secundy, United Planning Organization
- Dr. Edward A. Kane, Health Committee - D.C. Federation of Citizens Association
- Reverend John J. McGarraghy, Archdiocese of Washington
- Mr. Nelson C. Roots, President, D.C. Federation of Civic Associations, Inc.

Task Force on Law

Members of Task Force:

Mrs. Elyce Z. Ferster - Co-Director, The Mentally Retarded and the Law Study, George Washington University

Mrs. Blanche Collier - Asst. Institutional Administrator, District Training School

Charles De Roche, Esq. - Help for Exceptional Little People
Miss Selma Levine - Attorney, Representing D.C. Bar
Eugene Frank Mullin, Jr. Esq. - Attorney
Professor Joshue Okun - Georgetown Law School
Mr. Jerome Roach - Assoc. Professor of Social Work, Catholic University
William W. Ross, Esq. - Attorney
Mrs. Sigmund Timberg - Member-at-Large, Parent
Robert Weinberg, Esq. - Attorney

TASK FORCE ON PERSONNEL NEEDS

PERSONNEL AREA	CHAIRMAN OR RESPONSIBLE PERSON
Teachers	Dr. Betty Simms
Nurses	Miss Dorothy Grant
Doctors and Dentists	Dr. Robert Clayton
Rehabilitators	Dr. Raymond Ehrle
Recreators	Mr. Ron Johnson
Social Workers	Mr. John Jamison
Clergy	Dr. Samuel Gandy
Speech Pathologists and Audiologists	Mr. Robert Honeygosky
Psychologists	Dr. Helen Peixotto
Human Development Assistants	
Chairman of Task Force	Dr. Philip Calcagno*
Education	Dr. Max Frankel

*Other members of the Task Force are Dr. Frederic Burke, Dr. Felix de la Cruz, Dr. Gertrude Justison, Mrs. Frances King and Dr. Richmond Paine.

Transportation

Members of Committee:

Mr. Carl Ligons - Asst. Supervisor of Education, Youth Center at Lorton - Chairman
Mrs. Margaret Bell - Administrator Asst., St. John's Child Development Center
Mr. Willie Clark - Driver for Pre-school Program, D.C. Recreation Department
Mr. Carl Jackson - Administrative Services Division, D.C.D.P. Health
Mr. William J. Fidler - Administrator, D.C. Society for Crippled Children
Mr. George Isbell - Representative of Parents of Kennedy Institute
Mrs. Chrystine C. Jaffe - Supervisor of Volunteers, Jewish Foundation for Retarded Children
Sister Agnes John - Teacher - Kennedy Institute
Miss Helen Jo Mitchell - Director-Coordinator, Recreation Programs for the Mentally Retarded, D.C. Department of Recreation
Mrs. Aretta Moore - Director of Program Help for Retarded Children, Inc.
Mr. Guy Puntch - Institutional Administrator, District Training School
Mrs. Elinor Ring - Director, Pilot School for Blind Children
Mr. Roger Q. White - Administrator Assistant, Pilot School for Blind Children

This committee has met several times and has recommended an in depth study of transportation problems and solutions. It has made a beginning on gathering information.

VOCATIONALLY RELATED SERVICES

Miss Arlene Blaha, Chairman, Chief, Services to the Mentally Retarded, D.C. Department of Vocational Rehabilitation
Mrs. Vivien Dailey, Selective Placement Specialist for Trade and Industrial Area, U.S. Employment Service
Miss Pat Hawkins, Psychologist, Services to the Mentally Retarded, Department of Vocational Rehabilitation
Mrs. Aretta Moore, Acting Director, Help for Retarded Children, Inc.
Mr. Herb Rabinowitz, Director, Rehabilitation Council, Health and Welfare Council (former director)
Mr. Richard Sheppard, Director, Vocational-Evaluation Unit, D.C. Department of Vocational Rehabilitation
Mr. David Songer, Director of DVR, Eastern High School Project
Mrs. Edith A. Verant, Chief, Staff Services Division, U.S. Employment Service
Mrs. Kathleen Zellmer, Teacher, D.C. Schools, Help for Exceptional Little People